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WILLIAM N. MACARTNEY, M.D.

NEW YORK STATE
DEPARTMENT OF HEALTH
ALBANY, N. Y.

Fifty Years

A COUNTRY DOCTOR

BY WILLIAM N. MACARTNEY, M.D.



1938

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To the perfect teammate

My Wife

CAROLINE CLAGHORN MACARTNEY



FOREWORD

THE prevailing opinion is that the day of the general practitioner is passing or past and that of the specialist has arrived: this despite the fact that from two-thirds to three-fourths of our population are still treated by their family physicians. The species is a long way from extinction; they are a hardy breed and will survive. There are an immense number of them in the cities, towns and rural villages, far more than the sum total of all the specialists.

Many of them live in remote sections and are isolated to a great extent from their confrères, far removed from well-equipped hospitals, distant in point of time at least from the pathological laboratory. Such men are often unable to have serological and other tests early enough to verify a diagnosis. They must do the best they can for their patients under conditions which tax their knowledge, their judgment and resourcefulness to the limit. Their moral courage and stamina are subjected to tests as severe as can be found in any field of human endeavor. In their practice emergencies arise where there is little time for extensive reading of voluminous treatises or for the summoning of skilled assistants who will be delayed by long journeys over bad roads or by other handicaps. Here the science of medicine must largely be subordinated to its art.

Such courageous souls, battling more or less single-handed with pain, torment and suffering, fighting the grim reaper that spares not the head of the large family, the sole wage-earner, the mother with her manifold duties and responsibilities, or the only and beloved child, need no apologist. The general practitioner usually has the intestinal equipment to

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run under his own power and he is not readily eviscerated. He is independent and is usually an advocate of personal liberty, both in speech and in other respects.

Motives are usually mixed. At one stage in the process of wine-making it is necessary to add certain agents to clarify the wine; it may now be advisable to clear my conscience by admitting that this book is written in some measure for my own entertainment and to confess that, in so doing, I have intentionally left off my time-honored frock coat and plug hat. Considering the thousands of medical books published annually, it would seem that one-half of one per cent of these might be allowed to depart from the customary stilted and stately manner, much as we are permitted to use a trace of pepper for seasoning.

The pastor of our church intimates that with delivering addresses before Rotarian, Kiwanis, and other gatherings in various places, and writing books, I am showing definite symptoms of the foot-and-mouth disease. Be this as it may, there are four doctors and one trained nurse in my immediate family all living within a stone's throw of each other, and now, with advancing years, I feel impelled to take a little time off and set down certain things before my memory, which is still clear, fades slowly or is swiftly blotted out.

The subject matter of this book is largely confined to my own personal observations and deductions, and will for this reason be necessarily incomplete. One must choose between this and the greater evil of being to a large degree a mere copy-cat. The profession as a whole is thereby relieved of any responsibility for my personal opinions.

It is not an encyclopedia covering, however briefly, everything from Abdominal Distention to Zuni Itch, for which reason it is not a re-hash of what has been previously written by others far better fitted in every way for the task. It is not littered with long quotations from the powers that be nor padded with innumerable bibliographic references. Subjects on which the writer can claim no special knowledge or experi-

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ence are omitted, for second-hand goods meet with general disfavor. Technical terms and cumbersome phraseology will be excluded and plain English substituted so far as possible, even though the purist shudders at the homely idiom of the vernacular. Pure English, like pure gold, when beaten extremely thin makes excellent gilding but is of little use, otherwise.

The average doctor's speech is usually clear, terse, simple and understandable, but when he writes a medical article his text tends to become water-logged; too many frills give his writing a fuzzy effect. I believe that both the spoken and the written word should, above all other considerations, be as keen and as sharp of barb as a Mustad hook, in order to catch and hold the attention.

Sutherland, in *The Arches of the Years*, says, "It is insufferable that a sentence should have to be read a half dozen times before its meaning can be discerned by an intelligent person reading his native language."

I have had a long and arduous experience in private practice. I am not without hospital experience and, like many others, my work has developed along some special lines. I am making an honest effort to give my observations and deductions, based on a ripe, but it is hoped not over-ripe, experience, directly and lucidly.

Winston Churchill once blandly remarked of a Parliamentary opponent that he had "missed a fine opportunity for keeping quiet." Possibly this may well apply in my case, but I hope not.

I will try to follow the advice of the Chicago meat-packer: "Have something to say; say it; stop talking." Even at the risk of violating professional dignity, I have tried to make it essentially readable. It seems to me that a book which will not hold the reader's attention is seldom worth while, that is, unless it be a work of reference like an unabridged dictionary, and even this has been criticized as lacking in continuity.

Many of our local characters have a salty humor. Our Dr.

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Jenkins and Uncle Eph are not fictitious save to a limited extent. The one is a general practitioner of the older school, the other a whimsical and grizzled farmer with a mechanical turn of mind. Since they are both living they might be sensitive about being quoted too freely. To avoid giving possible offense it is needful to make their pictures composite to some extent and to use pseudonyms to sidestep any identification. Nevertheless, they are true to type.

The writer feels that this is an appropriate time to tell the reader of this book that it is likely to prove an unadulterated disappointment if he be of the type that will object to much irrelevant and possibly irreverent matter. It is about a 50-50 mixture of health guide and health guyed. However, "Some nonsense has a heap of truth in it," as Uncle Eph is prone to remark.

Now that I have gotten this off my conscience I feel better. At any rate, I feel that it will promote my peace—or piece—of mind.

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I

THE PIN-FEATHER STAGE

NEW YORK STATE
DEPARTMENT OF HEALTH
ALBANY, N. Y.

I BEGAN the study of medicine in 1880. Prior to this and up to my eighteenth year I was a happy-go-lucky lad, fond of fishing and hunting. Wild ducks were plentiful, grouse, woodcock, snowshoe rabbits abundant, and there were still passenger pigeons to be had. Baseball, football, and hockey, as we now know them, were to us non-existent. The forerunners of the latter game were, in winter, "shinny," played upon the frozen ponds and rivers with a wooden block and suitably curved black-alder sticks; in summer, the delightful and hilarious game of "rag," which was probably the dirtiest game ever invented, with the possible exception of that known, locally at least, as "The Wild Fox with the Bushy Tail," of which the present generation has little knowledge. We will be content to let it remain a mystery to those who have never known its impish delights.

The equipment for the game of rag was simple. Two pairs of goal-posts, an old gunny-sack or a yard of rag carpeting, a mop-pail filled with water, a discarded broom or fork handle for each player, and, for uniform, the oldest and scantiest clothing with which we could get by, were the essentials. The A. G. Spaldings of that day had nothing on us. The umpire and the captains of the two teams met midway between the goal-posts, the gunny-sack was soaked in the pail of water to make it heavy and then spread upon the ground, and, when the starting whoop was given, each captain strove to pick up the rag on the end of his broomstick and make a run to the goal. If tackled or blocked, he threw it to a member of his own team, tried to slip through with it or, as a last resort, he slapped it in the face of his opponent, thus blinding

him more or less temporarily. Early in the first inning the rag invariably became thoroughly saturated with mud with which it honored all applicants. The only rule of the game was that at its conclusion we all repaired to the nearest brook to wash both ourselves and our uniforms as thoroughly as is customary with boys in general. Occasionally the more venturesome, lacking a boat but equipped with two poles and a crude raft, went on "pole-her expeditions" up and down the Salmon River.

Meanwhile, during school hours, when I was fortunate enough to have a teacher who did not whale me too severely if I played hookey or indulged in similar lapses, I was slipping through my classes as smoothly as my ingenuity would permit and with as little effort as an eel slides through wet grass. The faculty at the Fort Covington Academy changed from year to year and some who were less sympathetic or who earnestly believed that strict guidance and discipline were essential to my future welfare, made trouble for all concerned. Grasp the aforesaid eel by the tail and try shoving him forward along a given course and you will have an apt illustration of the progress such teachers made when, with a lad of my disposition, they did not give him his head.

Grammar, geography, and history I put up with as necessary evils to be avoided as much as possible. Physical geography proved far more interesting. The higher mathematics, algebra and geometry, presented no difficulties and required little or no preparation. While the mental training may have been of some benefit, it was a case of easy, come, easy go and after leaving school I promptly forgot all I ever knew of these subjects. Botany, natural history, geology, natural philosophy, the sciences in general, I thoroughly enjoyed and the knowledge I gained stayed by me. Aside from all Gaul being divided into three parts, the chief remembrance I have of our Latin class is that it was, in a way, delightful. We were a congenial lot of boys and girls. We persuaded the principal of the academy that we could do much better work

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under the trees in the common than in a stuffy class-room. We did very little studying during these hours, as you have rightly guessed, but by studying late at night we kept well up in our work in Latin and thus managed to retain this desirable privilege.

My father, a Scotch-Irishman not given to many words, earnestly endeavored to teach his children to be self-reliant, to keep our promises to the letter, even though they were made solely to our individual selves, to pay one hundred cents on the dollar if God, aided and abetted by our own earnest efforts, permitted us to do so; to do our full duty as we saw it without shirking, and to maintain our own self-respect at all hazards. He would often give me a task to perform with the suggestion, "If you make a good job of this, I'll buy you a new nothing with a whistle in the end of it," an appropriate reward for the satisfactory completion of an obvious duty. These were homely virtues, but, even in the present Age of Repudiation and of whipping the devil around the stump, would seemingly merit serious consideration by those occupying high positions among the rulers of many of our great nations.

My mother had me up on the carpet one day gently remonstrating with me regarding my tendency to spend all my spare time, on Saturdays and during vacations, in the woods and fields. She made it quite clear that she did not disapprove of hunting and fishing, but that she felt I was overdoing it, thinking of little else. I said, "Mother, you know I would do anything possible to make you happy, but a boy must be busy about something. If you prefer, I will race horses, play pool, gamble, drink whiskey, or play 'round with the girls, whichever you think best, but, if you leave it to me, I would rather fish and hunt."

Her loving eyes looked deeply into mine for a moment, then, with a tender smile and a little pat, she turned back to her household duties.

The principal of the academy, Millard F. Perry, took me

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aside one day and said, "Macartney, you have gone about as far as you can go advantageously in this institution. What are you going to do when you leave school?"

I answered quite frankly that I had given the matter little or no thought.

"Then it is time you did. Do you want to learn a trade or to follow some mercantile pursuit?"

I said I did not.

"What about teaching school, for instance?"

"Not while there is nice clean gravel to shovel on the railroad right-of-way," I answered.

So he went down the list. I had been nicknamed "The Lawyer" by my schoolmates, probably because I had always liked to hear both sides of any given question, and was quite willing to take up the off side of an argument as a sporting proposition. When he suggested the law as a profession, I promptly turned it down.

On numerous occasions when I had been facing the blackboard for punishment following infraction of the rules, shrieks of laughter had resulted from crayon caricatures I had swiftly made when the principal's attention was diverted for the moment.

"How about becoming an artist? You draw fairly well, and you have a trick of catching facial expressions," he said with a wry grin.

"Sir," I said soberly, "I would not care to spend my life making pictures when the real things are so much better."

"Then what about studying medicine?"

"By Jove! That might be worth a fellow's while."

I had come to an immediate decision, a decision which I have never for a moment regretted. So that was that.

Shortly after this, in April, 1880, Dr. William Gillis offered me a three year apprenticeship in his drugstore. I was to receive seventy-five dollars for the first year's work, one hundred for the second, and two hundred for the third, a total of three hundred and seventy-five dollars for three years'

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work, without board or lodging. Such apprenticeships and such wages were not uncommon at that time in small rural communities. Realizing that he had a fairly good working library and that a knowledge of pharmacy might be of value to me, I accepted his offer. In fact, I remained in his employ for some time after my apprenticeship ended. Meanwhile, I earned money on the side by gunsmithing, taxidermy, and sign painting, chiefly at night after the pharmacy was closed. Taking into consideration that during the first two years my wages averaged \$7.29 per month, my efforts to supplement my regular wage would seem excusable.

Next door to the pharmacy was a hardware store operated by a wag by the name of Sidney J. Stewart. A stranger from a neighboring county drove into town one morning with two ruffed grouse which he wished to have mounted. He stopped in front of Stewart's place and asked where the taxidermist lived. Stewart scratched his head, appearing puzzled, then broke out with an expansive smile and said, "Taxidermist, taxidermist. Oh, I think I know whom you mean. It's Macartney, the fellow who upholsters hens."

It was during this pill-rolling, bird-stuffing, gunsmithing period that a farmer brought in a gray screech owl — some of these screech owls have a distinct reddish hue — which he had captured alive in his barn. I could not bear the thought of killing that cute little owl and then mounting him. Day after day I looked at him sorrowfully, for I sorely needed the money. Then a friend of mine gave me one, dead. This one I substituted for the other and was happy once more. For a number of days the live one refused all food and at last I began to feed him water with a medicine dropper and push bits of raw meat down his gullet with a slate pencil. One day he found a dead bluejay in the back office and ate the whole of that jay during the day, the jay being the heavier of the two. He would eat all he was able, digest it and regurgitate the feathers and bones, then resume eating. He got to be quite tame and I made notes and sketches of him.

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One day a fellow came in and saw him perched on top of a wall case. He said, "You haven't got that bird's ears right." He knew nothing about birds but was always criticizing my mounts in a very superior way. One of those chaps that make you view the idea of selective homicide with some favor. After discussing the matter with him, I said, "He's soft yet. *You* fix his ears the way they should be." When he reached for the owl, the bird spread his wings and began snapping his beak at him. I was square with the world once more.

One evening a girl came in, one of the loveliest girls I ever knew. "Have you mounted any birds lately?" she asked. I had just seen the little owl perched on the corner of the desk in the back room. We stood in the doorway and I pointed out the owl to her.

"Do you know, I believe that this is the nicest one you have ever done. Every feather is in place and he almost looks alive!"

Grinning, I moved the kerosene lamp slowly to one side and the eyes and head of the bird naturally followed. Libbie said, "Huh! You can't fool me. You've got him on wires!"

After some two months' acquaintanceship, I gave the little owl his freedom.

As I stated, Dr. Gillis had a good "working" library. I recall that his sole book on the eye was by Lawrence, an English author. It was quite a large book, calf-bound. In this volume I found a description of two unusual cases of refractive error which the author considered so remarkable that he gave a very full and complete description of both. Such was our knowledge of astigmatism at that time and place. Nevertheless, I learned much of value during my sojourn with this country doctor. He was of Scotch descent, had studied medicine with Roswell P. Bates — likewise of Fort Covington and one of our early pioneers in abdominal surgery, had attended the medical college at Castleton, Vermont, and, like his predecessor, Bates, was considered one of the best physicians and most skilled surgeons at that time in Northern New York. God had been good to him. He was a man of magnifi-

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cent physique, six feet, three inches in height, of commanding presence, with a leonine head; a veritable Airedale of a man, a natural-born orator, a man of sound judgment, of sterling character, public-spirited and of great native ability. His only surviving descendant is Miss Frances Cushman, of Fort Covington, N. Y.

Some of these old-time doctors treated fractures and similar conditions remarkably well. A natural bone-setter could apparently set almost any fracture successfully except a broken egg. Deft fingers and common sense preceded the X-ray by many centuries. I once asked Dr. Gillis how he was able to treat a case of cholera morbus in the algid stage before the hypodermic needle came into use. On account of the incessant vomiting and purging, the patient rapidly becomes shrunken, livid, corpse-like, moribund, and the only effective remedy, so far as I knew, was a large dose of morphine hypodermically, since no medicine could be retained either by the mouth or by enema. He told me that he used to raise a blister on the patient and rub in powdered opium or morphia on the raw surface. When I suggested that this involved a dangerous delay, since a fly blister meant some six hours or more before the blister raised, he smiled and told me that he could raise a blister in a very few minutes by the application of a wide-mouthed bottle containing a mixture of ammonia and turpentine.

The spelling of these doctors of a vanished age did not always compare favorably with their efficiency as practitioners. I recall my quiet amusement when three of them were puzzled in making out a certificate relative to a patient with cirrhosis of the liver. One of them insisted that it should be spelled "serosis," the second, "schirrosis," and the third, "chirrosus," finally compromising on one that was no nearer the bull's-eye.

One of our local physicians filed a death certificate with the Registrar. It was his custom to put in not only the actual cause of death, but a long list of complicating ailments. His

handwriting was execrable, and one day the Registrar was puzzling over this while attempting to record the medical terms used. A bystander solved his problem by suggesting, "Put down that there on the third line, 'Bright's Disease'; that's enough to kill him."

I found that the practice of pharmacy promoted the development of a sixth sense. A layman's order for "Scoxamun-sion" meant Scott's Emulsion; "Nick Risaid" meant nitric acid; "Recipricity" called for red precipitate; "Sytyles podus" was properly translated Seidlitz powders, and an order written on an old envelope demanded a "Gros of soppermint." This had me treed for a while. Inquiry developed the fact that it was to be used as a bed-bug discourager and I hope that the corrosive sublimate I dispensed filled all requirements.

Only a few days ago I ran across a letter from one Ame Merritt, dated in 1881. The concluding paragraph regarding his children who were troubled with lumbricoid worms is:

"Rig me up the stuf to cyore there cofs and nilate (annihilate) the crewel werms and I will not gromble at the prize."

I asked one of our customers recently bereaved what his father had died of and he said, "Well, the doctor wrote on the certificate that it was general diabolicky." From what I knew of the deceased I did not question the accuracy of his diagnosis.

In my early boyhood I had learned how to hypnotize hens by placing them on their backs and stroking their heads, whereupon they would go to sleep for some length of time, and I now made use of this and developed the method further when customers brought in wing-broken herons or crippled eagles and fish-hawks for mounting. I learned how to handle such birds safely and to put them out of misery mercifully.

With our Public Health nursing service it is now a far cry from the days when the small boy was wont to come into the drugstore with the request, "Maw sent me to ask you

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for an almanac so she will know when she can wean the baby.”

At that time powdered red cinchona bark was a standard remedy. A heaping tablespoonful stirred up in a cup of water was the customary dose. It was about as appetizing as a bowl of tan-bark gruel. Quinine, an elegant white powder, gradually took its place. Planten's empty capsules came into vogue and I ordered a supply. To induce our customers to take these I had to demonstrate that they were shatter-proof by chewing and swallowing the empty capsules. One lady carefully emptied the quinine out of two dozen capsules, took the quinine in powder form and sent the box back with a polite note asking me if I would please refill all those cute little bottles.

Up to the time when I entered the pharmacy I had been like the little girl whose older brother caught her stealing jam. Being of a serious turn of mind he said, “Mabel, do you want to go to Hell?”

“Wait, Bobby, till I det my hat,” was her reply.

Now I was placed in a position of some responsibility with little or no supervision, making up all our pharmaceuticals, rolling out pills on a hand machine, putting up prescriptions, and the experience sobered me. It was at this time I grew to man's estate.

I had always longed for a dog and I bought a brown cocker spaniel, named Dom Pedro, for two dollars. When I brought him home my family strenuously objected. I said, “If he goes, I go too.” He was a constant joy and delight from then on. One of his funny tricks was to bring me my hat at noon and at 6 P. M., which he invariably did. At first I thought he heard the town clock strike, his timing was so perfect, but I often saw him bringing my hat before the clock started striking.

I was offered a chance to become an analytical chemist for a firm that subsequently became a big corporation and an opportunity to become a partner in a drugstore in a large city,

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but remained steadfast in my determination to study medicine and, having saved up seven hundred and some odd dollars, I started in on my medical course. Since one thing, like an emetic, is prone to bring up another, I am reminded of the two clergymen who were discussing their ministerial matters. One of them said, "I have some three hundred and odd members in my congregation."

The other remarked, "I have over four hundred, *all* odd."

My seven hundred dollars were all odd. In retrospect, it looks as if it must have been some undertaking, and to attempt it under present-day conditions would, I fear, cramp my style. Gentle reader, let me whisper in your shell-like ear. It simply isn't being done now. Even then it was almost as rare as a mule's grandson. Anyhow, it shows what marvelous strides medical progress is making. The poor but ambitious country lad is ruled out, even in this decade of governmental elephantiasis and other mental disorders.

When the news got out that I was going to New York to take a medical course, one of our customers told me bluntly, "You'll make a hell of a doctor." At times when the sky is overcast because things go wrong with some dearly beloved patient despite my utmost efforts, I fear that he was right. Nevertheless, I subsequently acted as his family physician over a long period of years and did a successful major operation on him when he was ninety-four years of age, some two years before he died of cerebral hemorrhage.

Underneath all this I was becoming more and more convinced that my chosen profession was one of the great factors in the betterment of mankind, in the slow but unfaltering progress through the ages toward a better race and that even I, a humble and insignificant unit in that profession, might eventually be of some service to humanity.

II

VENTURING FROM THE NEST

I KNEW almost no one in any of the large cities or university towns and the reason I went to New York for my medical course was that I realized the wealth of clinical material available in that city as compared with medical colleges closer at hand. Another reason appealed to me. On account of my limited funds, an intensive course was essential. The three leading colleges were the College of Physicians and Surgeons of Columbia University, the Bellevue Medical College, and the Medical Department of the University of the City of New York. After talking with various doctors and finding that each was recommending his own Alma Mater, I wiped the slate clean and chose the University of the City of New York, since it had the largest enrollment of students, thinking it safe to follow the crowd.

The fees were very reasonable. Twenty dollars each for a course of lectures on the seven major branches each year, also a matriculation fee each year of five dollars, and a dissecting-room fee of ten dollars. There were other fees for special courses. The faculty insisted on certain textbooks, and I recall that I refused to buy one by a German author on the ground that he gave lengthy descriptions of the history, morbid anatomy, pathology, and diagnosis of many incurable diseases and dismissed the treatment with a curt statement that "the disease is incurable." I fully realized that many patients know that their condition is hopeless, but they are more than grateful for even temporary alleviation of distressing symptoms.

The new Loomis Laboratory was getting into its stride and the graded system of medical instruction was slowly

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forging to the front. Board and lodging for medical students ran from five to six dollars per week. The boarding houses were of the shabbiest sort, the better class refusing medical students.

Sometimes our meals were at seventh-rate restaurants. One Thanksgiving Day during my first term I saw a sign, "Roast Turkey, 35 cents" and yielded to temptation. The waiter brought me in two turkey necks only, which I refused on a technicality that it was turkey I had ordered, not a monstrosity with a double neck. After this experience I decided that such extras were things I would deny myself during Lent and likewise during the remaining months.

Meanwhile I was rolling along like a hoop snake, making both ends meet somehow. I was daily becoming more enamored with Medicine. Happily, "My heart was rife with the joy of life for I loved you even then." The college course was intensive. We had long hours and hard work. Lectures began at 9. A. M. and we took a half hour at noon for lunch; laboratory work until 2 P. M.; lectures and clinics to 6; one hour for dinner; quizzes and dissections until late at night; this for six days in the week save on Monday when didactic lectures began at 10 A. M. to give commuters time to reach college, and Saturday afternoon when we closed at 3 P. M. Sundays we reviewed our week's work in our lodgings.

You cannot keep seven or eight hundred young men under such high pressure indefinitely. Riots and general knock-down and drag-outs would occur from time to time. One afternoon in midwinter, after being penned up for months, one of our professors, William H. Polk, dubbed by the students the "late Professor Polk," was unusually late. A restless half hour passed, when one student threw a wad of paper at another and instantly the air was full of flying missiles; galoshes, notebooks, cushions and anything movable hurtled throughout the amphitheater. Through the dust I saw Dr. Polk peep in and hastily retire. No one was seriously hurt but much property damage resulted before

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quiet was restored and the mob dispersed for the day. On the following forenoon many were up "on the carpet" for questioning but, since the affair was spontaneous and there were no ringleaders, the whole student body being involved, the faculty wisely decided not to expel or penalize anyone.

On another occasion there was a grand riot and two stalwart policemen arrived. They were promptly surrounded by the dense mass of rioters who squeezed up until the two cops popped up above the crowd like library paste from a collapsible tube. The solid mass moved out to the street and deposited them carefully on the pavement with this good-humored advice, "This is just a little family affair and we'd hate to have anything happen to you, so you'd better keep out until we get matters settled."

An elderly doctor, A. J. Swaney of Gallatin, Tenn., roomed with me for some months, a very amiable gentleman. He said to me one day, "Macartney, I like to go to the hoss races and the theater, but I can't find my way back home. This here asking a policeman to take me home when, as you know, I never touch likker, is humiliating. Now I want to make a proposition. I've got money and you've got brains. Let's consolidate and go places. My part is to pay all expenses and yours is to get me there and back again all right." So we combined forces and had a good time as often as occasion would permit, at times making the occasion to order. I had one chance to return his confidence in me and his kindness. As I was leaving our room in the boarding house, a room occupied by four of us, I noticed a roll of bills which he had evidently forgotten, large enough to choke a mammoth, protruding from beneath his pillow. Upon his return that evening, I asked him for a loan of ten dollars. He went through all of his pockets several times, and at last an expression of dismay crossed his features. I kept him on tenterhooks for a while and at length unlocked my trunk and returned his wad.

One day I ran out of funds due to failure in the remission

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of an installment of my original seven hundred dollars. I had nothing but a Canadian five-dollar bill which no one would accept. I spent a half day among the foreign exchange brokers without success. It was a peculiar-looking bill on the Bank of British North America and they would have none of it. I was arguing the matter desperately with one broker when a tall man stepped out from the crowd. "Young man, let me see that bill." He handed me a fiver in United States currency and, when I urged him to take the discount, he told me that he was returning to Manitoba from Costa Rica, that the Canadian bill was a perfectly good one and that he could use it. When I persisted, he smilingly put his hand on my shoulder and said, "My lad, if this is any favor to you, pass it along to the next fellow." One of the finest one-sentence sermons I ever heard and one that I have not only treasured in my memory, but have made practical use of in many instances.

In the main hall of the College there was a bulletin board. Arriving early one morning, I read an announcement thereon by one of our professors who was inclined to corpulence. No one being in sight, I took a piece of chalk and added a line at the bottom so that it read:

"An address will be given at 8 P. M. at the Academy of
Medicine by Professor O. B. Naught. Subject,

The Etiology and Management of Abdominal Obesity
or, Why Am I Pursy?"

Then I discreetly retired behind a distant pillar and watched results. It took very little to create a diversion in those high-tension college days.

Among the professors was J. Williston Wright. The students loved him. He was deliberate in movement and in speech but there was no lost motion. His lectures were a delight to all of us. We sat spellbound and were always sorry when his lecture ended. One day he came in, held up his

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hand for silence and said, "Prior to my lecture I have a few announcements to make. On Tuesday, on account of the illness of Professor John C. Draper, I will lecture in his stead at the customary time."

The boys were delighted and manifested their approval.

"On account of the contemplated absence of Professor Thomson, who is to attend an Association meeting at Washington, I have been requested to fill in his time from 10 to 11 A. M. on Wednesday." The students cheered, stamped and clapped in delight.

"On Thursday, Dr. Loomis will be in Albany to get approval of certain changes in our charter and arrangements have been made for me to fill in his place at 2 P. M." The applause was uproarious.

"On Friday, by special request, I will hold the usual clinic at Bellevue Hospital in place of Dr. Stephen Smith."

Waiting for some minutes in order to be heard, he held up his hand for silence and said, "On Monday I will dispense with the rest of the Faculty and run this whole damned institution myself."

William H. Thomson, Professor of Materia Medica, was a marvel. His great delight was to hold clinics on nervous diseases and make a diagnosis without examination or asking the patient questions. At this he was an expert, having, I believe, studied under Dr. Joseph Bell of Edinburgh, the original model from which Dr. Conan Doyle created Sherlock Holmes. Dr. Thomson had a chronic laryngeal affection which interfered with good delivery of his lectures, but was possessed of great originality and had an orderly mind.

Dr. Alfred E. Loomis was a wonderful lecturer, his fame being such that many students from other colleges came to hear him. He was dark, had a walrus mustache, was a forcible speaker with a good delivery.

During my first term, John C. Draper was Professor of Chemistry. He had a special class in laboratory chemistry which two assistants conducted: Draper himself seldom

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appeared. I took this special class, but, on examination, was flunked. Dumfounded, for I had worked earnestly and was already fairly well versed in chemistry, I interviewed the Lecturer in chemistry who was in direct charge of the class. He said that I had simply failed to pass, and that was that. In desperation, I later sought out the second assistant. "Oh, you're the man who got knocked out because you found an excess of urea in a normal specimen of urine."

"But there *was* an excess of urea in it." I protested.

"Sure there was. Not very much, but I saw it in your test tube. You were the only one that found it because you exercised more care. The first assistant tested all these specimens beforehand and he *had* to turn you down or admit to Draper that he had been careless. Hold your horses and I will see what I can do."

A few days later I was given another examination and it was so dead easy that I couldn't have missed it in the dark. The matter was thus adjusted and the Lecturer's skin was saved.

Draper died and Rudolph A. Witthaus succeeded to the chair. He was an expert chemist but never popular with the student body. We called him The Prussian. One incident will illustrate. Prior to the final examination he announced that, instead of the customary number of questions, there would be an additional one which, if answered correctly, would not count but, if not answered correctly would necessitate our taking the entire course over again. The students hissed him. He eyed the assembly and said scornfully, "There are two members of animate creatures who hiss. One is the goose, which we pluck. The other is the snake, which we crush under our heel." With a suggestive gesture of one foot he turned and left the lecture room.

The professor of orthopedic surgery, Dr. A. M. Phelps, was a genius and originated many new and successful methods of treatment. Not a scholar and not overly refined, but a remarkable man in many ways. One day at a consulta-

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tion with Dr. William Hingston, then the foremost physician in Montreal, the conversation at the dinner table led up to Dr. Phelps, who had practiced medicine for a number of years in Chateaugay, N. Y. Dr. Hingston was a cultured, precise, and dignified gentleman of the old school. I recall with glee his remark, made with his hands clasped in front of him, bishopwise, "I never had the pleasure of meeting Dr. Phelps save on one occasion. I got off the train at Chateaugay and Dr. Phelps met me with a double sleigh and driver. The roads were drifted full and the driver did not handle the situation to the entire satisfaction of Dr. Phelps, who at length took the reins and drove us with exceeding skill some three miles to the house of his patient. I admired the dexterity of his handling the team, but the *language* he used in addressing the driver and the team was s-i-m-p-l-y i-n-d-e-s-c-r-i-b-a-b-l-e."

Another unusual character was Maurice N. Miller, in his baggy old trousers. He was Director in the histological laboratory and his knowledge of pathology, histology, and bacteriology was unsurpassed at that time. Under his tutelage we learned how to prepare slides, to stain tissues and such micro-organisms as tubercle and tetanus bacilli and the like. Some of the raw students were clumsy in adjusting their microscopes, and I can see him now as he came down the line of tables, criticizing each student in turn. I tone down his remarks slightly, lest they set fire to the paper. "Holy Smoke! You're getting your light with your reflector from that fly on the ceiling instead of from the window as I told you." "For heaven's sake, don't try to crush the slide with your coarse adjustment." "Do you think you are handling a stone-crusher?" "You should be blasting ledges in the Rockies instead of handling a microscope."

He came and peeped through my instrument which, fortunately, I had just gotten properly lighted and focussed. "What's that on your slide?"

"I don't know, sir. I've had no time yet to examine it."

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"Well, what do you see?"

"So far, just a series of more or less parallel pink and white stripes." (It turned out to be a section of the kidney tubules.)

"Stripes! By the Magnificent, a rattlesnake has stripes."

"I beg your pardon, but a rattlesnake is *not* striped. A garter-snake is striped."

"Hell! I did not know we had a natural historian in this confounded class."

From that time on he was kindness itself and went to infinite pains to teach me all he could or, preferably, all I was capable of learning.

Incidentally, I may remark that I never smoked in the dissecting room or the pathological laboratory. I had too much respect for good tobacco.

Occasionally we went to other colleges to hear men of note, such as full-bearded T. Gaillard Thomas and side-whiskered Austin Flint the 1st, (there were three Austin Flints in succession, all men of ability) and I distinctly recall hearing the first say that he no longer employed bleeding in pneumonia; that while it was a remedy of great value, particularly in robust patients with high tension, it was very unpopular, whereupon I immediately decided that I would use it on the first case where I thought it was indicated.

There was no roll call or other check upon our attendance. The attitude of the faculty seemed to be that if we missed a lecture or a clinic, so much the worse for us. At the end of my first-year course, in March, my funds were getting low. Early in the succeeding fall I paid my matriculation fee ahead of time and never went near New York City. Apparently, I was never missed. Meanwhile I strove mightily to earn more money and returned the third year. The only real examinations we had were the finals, and, lacking one year during which they may have lectured on anything or nothing so far as I knew, I came up for the written examinations which took nearly a week. I had little hope that I would pass, being absent the second year. I think the examinations must

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have been impartial, for we had a large enrollment; some two hundred came up for the finals and I knew only one member of the faculty, Dr. Phelps, whom I had met once. I stood third in the list of honor men. The first, Dr. Samuel Cummings, had his choice of prizes and chose one of the four much coveted internships in Bellevue Hospital. The highest twenty were given a competitive examination for the remaining prizes. Luckily, the prize I most earnestly desired, the third internship remaining which was on the surgical side of Bellevue, was still available and I took it.

In 1883, at which time I was a drug clerk, the New York State pharmacy law came into being. All druggists who were not actual owners of the business or those who had not had at least six years experience, as I recall it, were required to take the examination before the State Board of Pharmacy and not less than three years' experience was necessary before we could even take the examinations. In my quandary, I told my employer that I would have to quit, since I had served but little over two years. He laughed and said, "I will attend to that."

"But I haven't worked at it that long," I protested.

"You've done more than three years' work in the two years you've been here," he replied.

Armed with the required certificate I took the examinations and was fortunate enough to have the third highest standing in the State. The conclusion is inescapable. I was, always had been, and always would be a third-rater. It had been proven three times in succession.

I have taken a good many examinations, the last one in Florida, and I have been up against a number of trick questions. In this pharmacy examination we were given a number of crude drugs to identify. Among them was one little oblong block about one by one and three-eighths inches in size. It was of a nice buff color, looked like an India-rubber eraser and it passed around the applicants for the second time, each one shaking his head sadly. On the second round

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I caught a faint odor which I tried to recall. Slicing off a little bit I put it gingerly in my mouth. It was a piece of smoothly sandpapered slippery elm! The rest were all watching me, followed suit and the smile became general.

In another examination a question was, "If you found a pound bottle of unlabeled hydrochloric acid in your back room, state how you would identify it with certainty and how you would determine its strength." I gave the silver and other tests to determine its strength, and wound up by writing, "This would be a silly way of doing it. What I would actually do would be to throw the blamed stuff in the gutter, fish out thirty cents, buy a fresh bottle and take no chances." A chemical test with what is equally important, tests for the presence of arsenic and similar substances, would run into a lot of money.

Another question was, "If you gave a patient a quart of milk on an empty stomach, describe the process of digestion, assimilation and elimination."

I stated what I knew about the digestion of milk but added, "It would probably not be digested or assimilated and would likely be eliminated suddenly by vomiting, if the patient were lucky."

The worst one of all was this, "Give the atomic weights of the following twenty elements. . . ." I got peeved at that one. These atomic weights are computed on the basis of hydrogen and may run from nitrogen 14.044 to lead 206.92 or almost any other decimal figure in a given instance. My answer was as follows:

"This is a perfect example of a blame-fool question and guaranteed chemically pure. I wouldn't answer it if I could, which I neither deny nor admit. I don't intend to use what brain I possess as an attic in which to store useless rubbish. I prefer to keep it a well-oiled machine which will function smoothly and efficiently. When I need to ascertain the weight of a given element, I turn to page 217 of your own Manual of Chemistry and copy it off. Hitherto I have taken

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it for granted that this table was correct but, after you asked the above question, I have lost all respect for its accuracy.”

Perhaps the examiner, in his sardonic way, was simply endeavoring to get our reactions. At any rate, somewhat to my astonishment after making this outburst, I got 100 per cent on this chemistry examination.

III

THE BLIZZARD

AFTER graduating I stocked up with a few necessary instruments and was ready to start home on Monday morning. I had reserved sufficient funds to pay incidental expenses and purchase my railway ticket, but the blizzard of 1888 blocked that move. I fought my way to the expressman. The customary charge for delivering a trunk at the Grand Central was 35 cents. It is now \$1.35. The expressman shook his head doubtfully, he would not guarantee delivery but if I would deposit \$5.00 he would make the attempt. This did not fit in with my budget so I went back to my boarding house. It was better so, though I did not realize it at the time.

The blizzard drove us all to shelter; traffic was paralyzed, no trains came in or left the city. It was reported to have cost some four hundred lives in the city of New York. The wind velocity was terrific. The Hudson River and the East River were frozen across for the first time in many years. People crossed the latter on foot. It caught the city wholly unprepared and enormous suffering ensued. It created an unfortunate situation for which, however, no one was to blame.

Fresh food was not to be had. Babies were fed on condensed milk and such substitutes as were available. Our landlady managed to feed us after a fashion but we ran out of tobacco. Several of my roommates ventured out to renew our supplies but returned empty-handed. Some had found the stores closed, others had given up the fight against the storm. One of them said, rather philosophically, "I can get along without smoking in this world and I'll smoke good and plenty in the next, if I get what's coming to me. Why worry?"

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I volunteered to get a supply, bragging that I was born among the Eskimos, had two polar bear cubs for pets and playmates, and knew how to gain entrance into an igloo. I told them (and this part was true enough) how two years before I had been marooned on Sheep Island in Lac St. Francis in a blizzard. It was a bare island with a solitary tree and a fisherman's shack the size of a large packing-box, a crude affair made of driftwood, built with a fair roof and little else, for summer use. I told them how the Judge and I, with my little brown spaniel, had spent two days and a half in that raging storm without overcoats or mittens, without food, with nothing to do but walk up and down that little island and watch the drifting snow which hid all else from view, without sleep, rousing each other from that numb lethargy that soon ends in death, thawing out our frozen hands by the warmth of our naked skins as we stood with our backs to the 60-mile gale, and when the skies had cleared and the storm had abated somewhat, we had rowed ten miles back to camp. I blue-penciled some of the story as being too sentimental for that crowd: how the hardest part was when little Dom Pedro would sit up and beg me for food; how our journey across the heavy swells to the main shore was interrupted by an enormous wave which washed Dom overboard from his seat in the bow atop of a pile of ice-covered decoys, and how we managed, somehow, to turn back and lift him in; how another duck-hunter on another island on the lake was less fortunate, being alone, and how he was found some five days later sitting upright on a fallen log with his gun beside him, frozen hard.

Very sure of myself because of that earlier experience, I now started out gaily enough for the tobacconist, but found the storm much worse than I had anticipated. I would gladly have turned back but the comments of my roommates would have been harder to bear than the blizzard. It is not only the woman who pays and pays but the braggart as well. In this particular instance I believe I got paid on the spot, as it were,

for all my bragging about my ability to ascertain the points of the compass while traversing the Arctic wastes during the long polar nights by noting that the hair was longer, thicker and heavier on the north side of the first musk ox I encountered. They never knew how nearly spent I was on my return or how grateful I felt for the comfort of Mrs. Chevanne's kitchen range where I tarried some time, before with assumed nonchalance I went up to our rooms and distributed an ample supply of tobacco, cigars and cigarettes to that hard-boiled but smoke-starved bunch of roughnecks.

We had been an ill-assorted group before we weeded out a few undesirables. The day I arrived the landlady had introduced me to two other medical students, Dr. Brown from up-state and Dr. Smith of Texas. Smith again inquired my name and said emphatically, "No such name is permissible. Your name is Jones," and "Dr." Jones I remained.

Other boarders arrived. One always sponged his tobacco from the rest of us, which was all right save that he invariably found fault with it. "Why don't you get some decent tobacco?" he would ask. The deadly monotony of this got us. I had what, at the time, seemed a brilliant idea. We were smoking a long cut mixture of Turkish, Virginia and Perique called "Three Kings" and I took a box of rubber thread bands, cut them in small pieces, mixed them liberally with the Perique mixture, left the box in its accustomed place on the mantel and hid our other supply. My bright idea proved to be a dud. Like a sting-ray it was not only worthless but had a shocking come-back in its tail. I can still smell that mixture of Three Kings and rubber for he not only smoked up that entire box in our room but he still wearied us with his querulous question. "Why don't you get some decent tobacco?"

We sat at the windows and watched the blizzard gradually subside. The street slowly filled with the shovel brigade. Day laborers, saloon loafers, bums, the jobless, the poverty-stricken slum-dwellers, all the forlorn flotsam and jetsam

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of the city, pitiful wrecks of humanity, all set to work. I can see them now, a motley crew, half-clad in tattered garments, shawled and kilted with pieces of old blankets and quilts, their blue hands encased in old socks, their bluer feet wrapped in old gunny-sacks, their throats and ears muffled with anything that could be tied in place. Slowly and painfully these destitute creatures shoveled the street-car lines and the walks free of snow and traffic was resumed. We ventured forth to find the snow piled so high that passing vehicles were not visible save at intersections. I took the first train north on Thursday night. Some blizzard!

An Irishman said, just as he was about to be hanged, "This is going to be a lesson to me." My experience on that desolate island in Lac St. Francis was a lesson to me. I was then twenty-six years old and had always been finicky and notional about my eating. During the two and one-half days without food I had ample time for reflection and I made myself a promise that, if I ever got back to shore safely, I would be grateful for any kind of nourishing food if it were but clean and wholesome. I have a habit of keeping my promises even when made silently and to myself only. Upon my return I began to eat what was set before me and soon discovered that, through my unfortunate prejudices, I had been missing a lot of good things. One of my pet aversions had been lobster, the smell of which so nauseated me that I would have to leave the table. I forced myself to overcome this; later I managed to swallow small shreds of it much in the manner in which I took nauseous medicine, and eventually reached the point where I was very fond of it. We first endure, then pity, then embrace. To this day when I look over a bill of fare and find some food on the list that I have never eaten, I invariably order it. I have earnestly endeavored to follow this same principle in many other things than food, striving to overcome fancied dislikes and foolish prejudices which had no reasonable basis, and in the measure in which I have been able to do this, I have had keen enjoyment and benefited greatly.

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One more incident will be appreciated by any Scot. When we failed to return from Sheep Island on schedule, on the following morning, a force was organized which attempted to reach our camp some seven miles from the village, but the teams failed to get through on account of the drifts. On the following morning a small army of rescuers, with much difficulty, shoveled out the roads, reaching the camp about one o'clock in the afternoon, just as we rowed our ice-laden craft into the harbor. On arriving home I learned that my father, who was familiar with the tempestuous moods of Lac St. Francis, had paced the floor for two nights, but his sole comment, when he got me alone an hour or so later, was, "There is *one* thing about this that pleases me. You got into a bad scrape but you got out of it yourselves. No one had to *rescue* you."

The Scotch are not given to showing their feelings too openly. It recalls the story of the old woman who was drawing close to her end. She said to her husband who was wiping his eyes and smoothing her hand, "I hae been a guid wife to ye, Donald."

"Aye, aye, middlin', middlin'."

My father's comment on my safe arrival reminds me of another tale of this same lake, though I do not vouch either for its accuracy or originality. Two Glengarrians were crossing this nine-mile wide lake one dark November night and were caught in the drifting fog which was rising like steam from the comparatively warm water, blotting out lighthouses and all other landmarks. Lacking a compass, they were rowing without guidance and bailing constantly. At length Angus, who was at the oars, said, "We are in a bad case, Sandy."

"We are that, God help us," replied Sandy.

"Could ye drop yon dipper lang enough to put up a bit of a prayer?"

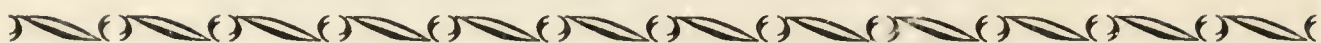
"I micht," said Sandy.

As he knelt in supplication, the skiff struck with a grating

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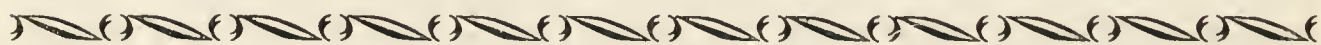
jar and Angus, feeling a rocky beach with his hand said, "Whisht yer gab, Sandy. We're beholden to naebody."

Both these blizzards came without much warning. In those days we had no weather bureau but an abundance of weather prophets, none of whom, however, could be relied on save one, my sister Sarah. Within limitations she could predict the weather with uncanny accuracy. She was a persistent early riser and loved to sweep off the steps and the front walk in the early morning hours when the rest of the family, including the hired help, were still sleeping soundly. While so engaged she would test the direction of the wind, note the cloud formation, the color of the morning sky and all those definite but indescribable color tones and atmospheric effects which, collectively, to the trained observer, are clear indications of forthcoming weather conditions. She would consult the weather glass and the thermometer and would eventually arrive at the breakfast table where we were all assembled. Then she would take a confirmatory look out of the north window and the west window and, seating herself at the table, would say with an air of finality, "Well, there is *something* coming." Though I heard her make this prediction many times over a long period of years, I never knew it to fail. *Something* always *did* come.



IV

FLEDGLING DAYS



THE worst attack of swelled head I ever had was in the fall of 1888 when I entered Bellevue Hospital as junior interne on the First Surgical Division. The Hospital was at that time reputed to be not only the oldest hospital on the continent but the greatest hospital for acute cases in the world. It had forty wards with twenty beds to each ward, giving a capacity of eight hundred. It had organized the first regular hospital ambulance system in 1869. The first school for trained nurses in the Americas started there in 1873. The Mills school for male nurses, another innovation, was put in operation there in 1888.

My ego was soon deflated. The juniors were known as "scrubs," an appropriate designation and one which showed the estimation in which they were held. They were the natural footballs of both the house and the senior internes. Discipline was strict and I was soon taught my place. The house surgeon was Charles W. Jackson; next under him was Samuel J. White. On my first day, in the dressing room, they asked me for my diagnosis in the case of a man whose hand Jackson was holding and whose forearm visibly sagged nearly two inches in the middle. Without going near the man I said, "Measles." They had expected me to examine the arm carefully and solemnly, and to announce that it was a fracture of both radius and ulna, which it obviously was. They had merely tried to put over a fast one.

Then came a leg to be bandaged. I had done a good deal of bandaging while in the pharmacy, had seen demonstrations galore in the clinics and had taken a special course in operative surgery and bandaging. I bandaged that leg while

they watched me critically. When I got all through, Jackson said, "No good. Do it over."

Humiliated, I said, "That would be of no use. I couldn't do it any better."

Jackson relented. "Don't take it to heart. That's the prettiest leg bandage I ever saw. It's the way they teach you in college but it's no good. Take it all off and I will show you how to apply one that he can wear for a week." He then taught me how to put on a real bandage.

I think it was the next day that he said, "Macartney, go two flights up the main stairway and turn to the left. The first door leads to my office. In the left-hand corner you will see a closet. Hanging on the inside of the door is a big blue ptomaine. Bring it here to me without delay."

I nodded and left. Ptomaine was a word which had just been born. Once out of sight I slipped into the park and spent the next hour on a settee in the shade, with a magazine and a cigarette. I saw that a search was being made, and at length someone spied me. Jackson arrived promptly, apparently in a towering rage, and demanded to know what I was doing there. "We must have discipline," he roared.

Taking another puff of smoke I said, "I have been doing my level best, sir, but when I opened your closet door that big blue ptomaine, which was hanging bat-like from a hook, flew by me and out of the open window. The last I saw of him he was hovering over Greenpoint and I have been patiently waiting for his return."

Jackson said gently, "Come on back now, if you've finished your cigarette."

Bellevue then was not what it is now. The main hospital building was quite old. There was a double flight of steps leading up to the main entrance and the railing crossing the front was from the Federal Hall in New York City. It is a matter of historical interest that, over this railing, George Washington took the oath of office as First President of the United States.

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Underneath, in the basement, was the admitting office, together with the drug department, stock rooms, etc. On the main floor was the office of Warden Fallon with the Medical Director's Room and numerous wards. The floors above were chiefly medical and surgical wards with the amphitheater at the top. In addition there were the Marquand, Townsend (with the Annex), Sturges and Insane pavilions and over the East River, a corrugated iron structure known as the Erysipelas Pavilion or "Sip." There were wards for prisoners, male and female, for alcoholics and, across the park, the Outdoor Poor department and the City Morgue. The Chapel of Christ the Consoler was reached through the hospital proper.

The drug department was in charge of Dr. Charles A. Rice, a quiet, unassuming man, but of vast knowledge, who headed the commission for the revision of the United States Pharmacopeia. The day I left the hospital to enter private practice was the only time I ever met him unofficially. I went in to shake hands with him. He said, "You're the only man we've had for years here whose prescriptions I never had to correct."

Within the buildings we had gaslights only, though there were arc lights on the streets. There were no telephones, unless the acoustic 'phone I built from two tin cans and a string of copper wire could be so designated. Through it I could be reached from the dressing room on the First Surgical.

The beds in the wards were of straw but the nurses were carefully instructed how to make them up *secundem artem*. Each morning they were shaken and leveled up, then beaten with a "tick-stick" until they were as smooth and as symmetrical as any modern mattress. In this the nurses took great pride.

The hospital plumbing was not only primitive but execrable. The water supply was unsafe for drinking. The Croton Reservoir was a favorite resort for suicides. Seven "floaters," a ghastly sight, arrived one day at the Morgue and

dulled our zest for the city water. We decided to use Hygeia bottled water, with a marked reduction in the incidence of typhoid and enteric diseases in the hospital staff.

My room or office was roomy and comfortable after a fashion but had no bathroom. The hospital furnished me with a little cockney Englishman as a body servant. Every morning he would bring in a large, saucer-shaped tin bathtub and fill it for me. If he had any other name than Steve or any past history, he never divulged it. This bath and the magnificent view of the East River from my front windows were the only luxuries provided.

There was an elevator and a spiral stairway running up nine flights to the Amphitheater. The elevator was so slow and inefficient that when in a hurry I would commonly run up the nine flights without stopping. One morning Professor Gouley stopped me as I was running up the stairs. "Don't do that, Doctor."

"Do what?" I asked.

"Run up stairs like that," he answered. "You will ruin your heart. You will not live three years if you continue doing it." I laughed and slowed down until he was out of sight. That was in 1888. It is now 1938. He missed it by forty-seven years so far, because I still run up stairs when in a hurry. It was a busy service and we were on duty twenty-four hours seven days in the week.

As a "scrub," it fell to me to do many a urinalysis every morning. It was sheer drudgery and, after giving the matter some thought, I devised a short system, eliminating a lot of lost motion without lessening the accuracy of the tests. I follow much the same method today.

There were some sixty-five female nurses when I first entered the hospital, all under the direct supervision of Miss Agnes S. Brennan. One noticeable feature was that a very large proportion of them were daughters of physicians or clergymen, proving, to my mind at least, that they were animated with a love of service. At night, one nurse had

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charge of two wards, forty beds. Their uniforms were washable gowns of seersucker, blue and white, their caps of organdie with ruching around the border, their aprons of bleached muslin.

Being the youngest of our family and having no immediate relatives or neighbors with very young children, it so happened that I never had held an infant in my arms. I dreaded the day when I would have to display my ignorance. It came all too soon. The elderly head nurse said reproachfully, "Dr. Macartney, isn't that a most peculiar way you are holding that baby?"

With a perfectly sober countenance I said, "Miss Howland, this is the way I *always* hold babies." And that was that.

New nurses were taken on probation and were known as "probes." During the middle of the night came a hurry call to one of the wards. In dressing gown and slippers, Dr. White and I ran hurriedly to the ward. A woman afflicted with an aneurism involving the subclavian and carotid arteries had been under observation for some time. During the night it had burst and she ran to the dressing room to call the night nurse and then back to bed, leaving a double trail of blood a foot wide en route. It was one of the most ghastly sights I ever witnessed and she was almost exsanguinated. We managed to plug the opening and control the hemorrhage in time but with nothing to spare, and the bed, the ward and all four of us were covered with blood. The "probe" started back to the dressing room with a tray of instruments. Dr. White said in an undertone, "Didn't that little 'probe' do well? She never even assisted in an operation until now."

"Yes, but watch her."

Just as she neared the door of the dressing room she swayed, dropping the instruments with a clatter on the floor. We reached her before she actually fell in a dead faint. It was all in the night's work.

The members of the house staff and the nurses were a

jolly lot and dearly loved to tease. They discovered a book-marker in one of my ready-reference books, one adorned with a lock of lovely silken brown hair tied with a narrow red ribbon. Internes and nurses strove to outdo each other in kidding me about my brown-haired girl. I grinned amiably and they never found out that the silky strands were from my beautiful little seal-brown cocker spaniel that was listening for my footsteps at home. My sister told me that one day, when I had been gone about a year, he turned up missing. They called and searched for Dom Pedro in vain. On the following morning one of the family had occasion to enter a dark closet and found him lying contentedly on an old coat of mine which had fallen off the hanger. On one occasion he had saved my life at his own imminent peril, but I evened that up by saving him when the chances were two to one that we both would perish.

Patients were admitted to the hospital at the office in the basement and from there went, or were carried on stretchers, to their respective wards. There were two stretcher bearers, old-timers, Pops and Mike. If they had any other names we never knew them. They had a peculiar gait, developed during years of careful placing of the feet to avoid jarring the sick. The story was current that a patient from a near-by street was brought to the hospital in an ambulance. When he was put in the ambulance his wife had thrown a white bedspread over him, and after he was admitted and a place assigned to him, Pops and Mike entered. There were always newspaper reporters about, and not desiring to make the front page, the patient had drawn the white spread over his face. Henry, the hunchback in the office, said in his guttural voice, "Pops, take this stretcher to 40."

Pops' eyesight and hearing not being of the best, they picked up stretcher and patient and started for the Morgue. The patient felt the wind blowing on him, peeped out, saw where they were carrying him and said, "Where in thunder are you taking me?"

"To the Morgue," answered Pops.

"But I'm not dead. I don't want to go to the Morgue."

"Lie down. Lie down," insisted Pops. "Guess the doctors know more about it than you do."

We used to serve in rotation as examiners in the admitting offices. I soon found the tricks of the trade. If there were a number of cases it always seemed to happen that the desirable ones, hernias, amputations and major operative cases supposed to be sent in rotation to Divisions 1, 2, 3, and 4, somehow landed up in the wards of the examining doctor. There were various maneuvers by which this could be accomplished. I watched carefully, even developed a system of espionage, until I had the goods on the other three divisions beyond all doubt. Meanwhile, I had been sending in all the cases in strict rotation. The house surgeons, vexed by some undesirable cases being squeezed in on them, grumbled to each other, adding, "Macartney is the only one that is square about it," but the practice continued unabated. Meanwhile, I had developed a number of new dodges, and following the principle that a man who gets a reputation for early rising can sleep as late as he will, I put in practice all my new schemes and we had a most astonishing number of desirable cases in my division from then on. One morning the house surgeon of another division met me in the hall. He said, "That was a rotten case you sent me yesterday evening. It should have gone to your own wards instead of mine and you know it."

I invited him up to my office, gave him a cigar and a light, asking him if he had any similar cases laid up against me. He had only the one. I got out my pocket memorandum and thumbed the pages until I found his. I said, "Doctor, here is a long list running over many months, cases which you or your examiner have put over on me. Under the circumstances don't you think you should forgive me this one slip?" It was a dirty Irish trick but, somehow, my conscience was never seriously disturbed over it. In our dressing room hung a

framed motto which had evidently been there for some years. It read, "No pain, no palm; no cross, no crown; no gall, no glory." When I had done something particularly cheeky, like this, I was accustomed to quote the last of the three phrases.

While I was still a "scrub," a woman with extensive burns was brought to our wards. She was pregnant and near term but her general condition was hopeless. We persuaded her husband to allow a Caesarean operation, but his consent was given to operate only in the event that his wife was actually dying. Dr. Jackson had been instructed by his superior, Dr. Stimson, to send for him at once if he saw that her death was impending, this with the provision that Jackson was to operate if there was insufficient time to send for the visiting surgeon. Dr. Jackson had been hoping that he would get this operation, but orders were orders, and one morning this unfortunate woman showed signs of dissolution. Jackson summoned up the hospital coupé and drove hurriedly for Professor Stimson.

Dr. White was temporarily absent and I was left in charge. Shortly after Dr. Jackson had left in the coupé, I was notified by the nurse that the patient appeared much worse and was apparently dying. The senior was away at the time so I operated without delay. Stimson and Jackson arrived after it was over and done with. At the dinner table that day, Stewart Douglas, in charge of the Insane Pavilion, inquired in his waggish manner if it were the custom on the First Surgical for the house surgeon and the senior to absent themselves when a real major operation was in the offing. Jackson was a good sport and, despite his disappointment, said, "I have the honor to inform you, sir, that on the First Surgical we have a junior who is quite capable of handling efficiently such emergencies during our absence."

While still a junior and acting in turn as examiner, a Turk by the name of Thomas Pasquale was brought in for treatment. I made a diagnosis of Raynaud's disease, or symmetri-

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cal gangrene. Little was known of it in those days. Jackson and White overturned my diagnosis and said that he had frozen both feet while sleeping in an open basement on a cold night. They also suggested that I was always going out of my way to find some rare disease. I retorted that one didn't find rare diseases if one never thought about them nor kept the possibility in mind; that I came from a section where we saw many cases of frostbite, and I stuck to my diagnosis. The matter was referred to the visiting surgeons and they pronounced it simple frostbite. I was thoroughly squelched. Both feet were amputated through the instep and the wounds healed promptly.

Fortune is an essentially feminine and fickle goddess, however, and one morning when Jackson and White were both temporarily away, I got a message that Dr. Stimson was awaiting me in the Directors' room. I said to him, "Dr. Stimson, have you any influence with the Commissioners of Charities and Correction who control all these hospitals?" He said that he had. "I earnestly wish you would have them look after our heating plant, for some of our patients are suffering severely from the cold."

"Can that be possible!"

"Yes, one of our patients in Ward 4 actually froze both feet in bed last night."

Stimson was keen as a bistoury and he immediately asked if it was the Turk and we went to look him over. At this juncture both Jackson and White returned. Stimson said, "We were all wrong and Macartney was right. It is a case of Raynaud's. Under the circumstances, don't you think it would be proper to let the junior amputate these feet?" They did and I did.

This Turk made a good recovery, but he was a recent immigrant, spoke no English at all, had no friends in this country and, with both feet gone, presented us with a problem, for we could not keep him indefinitely in a hospital where we were always short of beds. We sought some solu-

tion whereby he could earn a living for himself. Under present conditions he would have been put on relief permanently, or perhaps deported.

We clubbed together, got an ingenious local shoemaker to build him a pair of "boots," cutting down on cigarettes and carfare ourselves to pay for them. Thomas Pasquale himself suggested that if he could get a permit to sell shoelaces to incoming immigrants from the Customhouse steps, he could get along — provided he had a suitable tray and some laces. We wrote a round-robin to the Customs officials, later to the Collector of the Port, and all the way up the official ladder until we reached the President himself. Each one expressed his sympathy for the poor fellow, regretted that the law did not allow him to issue such a permit and referred us to the next higher up. The President's letter was very nice but he passed the buck, saying it would require a special Act of Congress, which, however, he would be very glad to sign. By this time we were all discouraged.

For once, at least, I had what still seems to me a bright idea. We had accumulated a big bunch of official documents with seals, red tape, etc. I tied all these together, wrapped them neatly in a bundle and handed them to Thomas, merely saying "All right," which was about the limit of his English. So far as I know he may be still selling shoe-strings from the steps, for I am certain that no one would ever go to the trouble of reading them all to ascertain whether he could or couldn't.

Semi-annually we had a new batch of juniors, eight in all, and it was the custom for us to give a banquet to the rest of the staff. This was known as the Junior Spread. We were each required to sing a song, dance a jig, make a speech or recite a poem. I got by with a limerick embodying an incident that occurred that same day, which delighted Jackson and we became close friends. His kindness to me is a remembrance that I cherish to this day. I know my frivolity must have been a sore trial to him at times.

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During this stage of my hospital "career" we had many operations on broken down and badly infected inguinal glands. It was deemed necessary to do a mass excision of the entire chain of glands, a difficult operation requiring about two hours to perform. The results were unsatisfactory; infection of a bad type being already present, we seldom got a primary union. As a special favor, Jackson promised me, the scrub, one of these operations. The time arrived, but with it there came a lot of urgent cases, and Dr. Jackson insisted that I must lose no time.

While etherizing a large number of similar cases, I had gotten another slant on the matter. My operation on this case took exactly six minutes, and was followed by a surprisingly quick recovery. Jackson said, "Mac, I'm going to let you try another and see if your luck holds." The method soon became established on our division. Dr. White dubbed it "The Lightning Rotary Operation."

Some eight or ten years later I was visiting the hospital and naturally gravitated to the First Surgical Division. The house surgeon was, I believe, a Dr. Hart, and I found him dressing one of the ward patients. I introduced myself as one of his remote ancestors (some fifteen or twenty "generations" back) in the way of house surgeons. With a sudden friendly grin he asked, "Are you the Macartney of the Lightning Rotary Operation?"

"What in the fervid lower regions do you know about it?" I inquired.

"Gone down in the traditions of the hospital," was his laconic answer.

We had a very active service in Bellevue and one exceedingly busy day matters had not gone as smoothly as usual. Around eight o'clock that evening while alone in my office, I was tormented by a throbbing lower molar which, now that I had a minute's leisure, I realized had been nagging me all day and was becoming unbearable. I got a pair of forceps, a shaving mirror and, with a certain measure of fortitude or

fiftytude, I removed it. The roots were infected, so I wrapped it in a bit of tissue paper and slipped it into my pocket for further examination under a magnifier. Later, while making my silent gum-shoe rounds among the sleeping patients, I entered the dressing room in Ward 1 just in time to hear my first assistant, Dr. Constable, say to the others present, "Wonder what was wrong with Mac today? He was cranky. He's not often like that. He's usually brim full of whimsical deviltry."

I smiled happily and said, "If thy right arm offend thee. . . ." unwrapped my evidence of focal infection and relieved a rather awkward situation.

At one o'clock one night I was hastily summoned to the Insane Pavilion, and on arrival in dressing gown and slippers, found a man, apparently dead, lying on the floor, with Dr. Douglas trying artificial respiration. The doctor had already opened the man's windpipe with a pen-knife. I pried the man's jaws open, made traction on his tongue, explored his throat with my fingers in search of some obstruction and did everything possible to resuscitate him, but without avail. Douglas said that he had been brought in by a policeman who had found him wandering about the streets and acting queerly; that he had a convulsion as soon as he entered the door, dying during the attack.

At the dinner table that day Douglas told me that friends had identified the body at the Morgue and had stated that he had been bitten by a dog some three weeks previously. Autopsy indicated that he had died of hydrophobia and two rabbits had been inoculated. Douglas dryly remarked, "The period of incubation in rabbits is about two days shorter than in human beings. If you had any hangnails you will have forty-eight hours in which you can make your will."

The rabbits developed the disease. There was a scratch on the forefinger of my right hand. As a matter of routine I had gone over to the dressing ward after leaving the Pavilion and had cauterized the scratch, which afforded me some

comfort and illustrated the advisability of cultivating good habits.

On another night I was called hurriedly to the dressing ward. The junior surgeon temporarily in charge had a patient come in with a swelling on his forehead. On the assumption that it was an ordinary abscess he had opened it with a bistoury and was wholly unprepared for the alarming hemorrhage which ensued. I found that he had opened an aneurism of the temporal artery which I had to tie in two places. This time it was the scrub who was taught the advisability of careful habits.

The staff on another division sent for me one day saying, "We have a patient here and are unable to understand what she says. You're from up Canada way and we thought you might help us out."

The old Scotchwoman looked at me and said, "These puir loons must be a bit daft. I hae been tellit them all ails me is stunes in me head and a pain in me oxter."

When I explained that stunes meant sharp neuralgic twinges and the other pain was in her armpit, she nodded, "There's one mon o' ye that has a mickle o' sense, forbye."

There was a small, dark, nervous, high-strung nurse named Miss Woolhopter, with a mop of dark, curly hair, who was making up some egg-nogs in Sturges Pavilion when I was making my rounds one morning. "If I make you a special egg-nog with a white cap, and a stick in it, I think it might fit your case. I hear you were operating most of the night. Just watch out that Miss Brennan doesn't come."

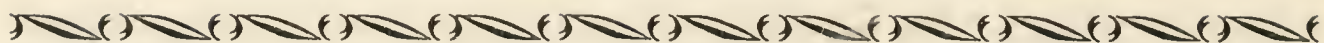
Presently I saw the Superintendent hurrying toward the Pavilion and warned the nurse. In her haste to hide the "special" she backed up against a tall ice-box upsetting a two quart pitcher of milk on top of the box. The pitcher balanced momentarily upside down on top of her black head drenching her from crown to heel, then fell with a crash to the floor just as Miss Brennan entered. In the ensuing confusion I

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had no difficulty in retrieving the eggnog and sending it to the place where all good drinks naturally go.

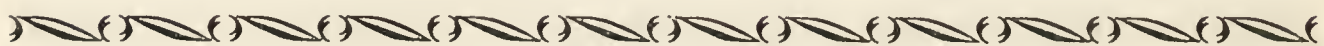
One of the staff, Dr. John T. Dooley, was a great mimic, and always wore a black frock coat which with his grave, clerical aspect led us to call him Father Dooley. Miss Woolhopper came rushing in one day, flung herself into a chair and wailed, "This has been an awful day. I'm all upset. Father Dooley, where do you think I'll go when I die?"

Father Dooley spread his hands in a priestly gesture and said with a benignant smile, "To hell in a whirlwind, my child. To hell in a whirlwind."



V

BELLEVUE BROODS AND COVEYS



THE world rolled on and time with it, a habit common to both. Jackson's term expired, White became house, I was now the senior and Herbert Lee Constable, big, amiable and blond, arrived as junior. There was no friction in our house staff. Both Jackson and White were good surgeons, pleasant companions, hard workers. They were not only kind to me but they were kind to their patients. Both had that saving sense of humor which smooths the rough places and lubricates life's grinding axles.

I did not serve long as senior, since White, much to our regret, resigned. He was one of the finest gentlemen that ever lived and we remained close friends for many years after, until he died. I recall one characteristic paragraph in a letter from him. "I'm coming up next week to visit with you, to hunt partridges, to have you teach me how to build a duck blind and, at night, to sit in your office and smoke while you are telling me stories about that darned little brown dog of yours."

I am the sole survivor of the staff of the First Surgical as it then existed. Jackson, White and Constable of the house staff, with Stephen Smith, Lewis A. Stimson and Frederick W. Gwyer, the visiting surgeons, have all departed. Stephen Smith was a grand old man, then nearing seventy. We all referred to him as "Old Stevie" not in disparagement but as a term of endearment. Kind, gentle, lovable Old Stevie of clerical aspect, still retained his full mental vigor. He lived well up into the nineties, bless his dear old soul. He was an enthusiast in antiseptic methods and, in principle, understood them thoroughly, though we had to watch him close-

ly, for his old habits were ingrained and he would often, quite unconsciously, violate the very rules which he was earnestly advocating.

This reminds me that he was operating one night under the twin gas-jets and complained bitterly of the light until I told him about an experience I had while serving my apprenticeship in pharmacy.

An artisan by the name of Pease had been duckshooting on the St. Lawrence River. On beaching his boat in front of the old stone house where he was staying, he pulled out his gun by the muzzle and the charge of duckshot completely shattered the upper arm and shoulder joint. Dr. Gillis was the only surgeon within reach and drove eight miles, accompanied by Dr. Macfie, to the stone house. The only available light was a kerosene hand lamp. Dr. Gillis proceeded to amputate the arm, together with part of the shoulder blade. They had *one* old-fashioned artery clamp and just as he severed the axillary artery and a big jet of blood the size of a lead pencil began spurting vigorously, Wright, the employer of Pease, a huge man, fainted and fell through the window. He had been standing on the broad stone window sill, holding the lamp, and he not only smashed the window but the lamp as well. Left in utter darkness, Macfie compressed the artery with his thumb and controlled the bleeding. Joe Lamay, the French-Canadian guide, ran down to his boat and returned with an iron fishing-jack and some pitch pine by which light the operation was concluded. Dr. Gillis tied the artery, arrested the minor bleeding points by the application of cloths wrung out of very hot water, sutured the wound, dressed it with pieces of clean old bed-sheeting, and the wound healed by first intention, leaving as "pretty" a stump as I ever saw.

That word pretty has various meanings. A few years ago I removed a cancerous breast, together with the axillary tissues and both the great and small pectoral muscles. Taking down the dressing about a week later, the patient caught

sight of the long wound with its row of stitches and cried, "Oh, isn't that the most horrible thing you ever saw?"

My wife, who had been my head nurse in Bellevue and usually assisted me in my operations, said in shocked protest, "Horrible? Why, it's one of the prettiest things I've ever seen." It had healed perfectly. It all depends upon the point of view.

Lewis Atterbury Stimson, father of Secretary of State Henry L. Stimson, was a surgeon of amazing ability and skill. He was born in 1844. A man of fine presence, with a manner of distinction, he seemed at first reserved, austere, and coldly scientific. I was to learn on intimate acquaintance that he wore this coat of mail in public to protect the very real tenderness underneath. The only time I ever saw him show any trace of emotion in public was at the conclusion of a difficult, bloody, and apparently hopeless operation on a cancer of the neck. He flung down the last instrument used and said earnestly, "I wish to God that I might never see another cancer."

An old negro was brought in one day with his leg hopelessly crushed by the falling of a huge rock. I immediately notified Stimson, as was my duty. He said, "Go ahead and amputate his leg just below the knee, but you will doubtless have a dead darky on your hands." I asked him why and he, in turn, asked me how many one-legged negroes I had seen.

I thought the matter over, gave the old darky a good drink of whiskey, a shot of morphine and, as he grew happier, suggested that he take a little ether while I was "fixing" up his leg. He readily agreed and, warning all hands not to talk, I got one of his old socks, a clean stocking and a board splint. I stuffed the stocking with excelsior, slipped his sock over this, fastened it all to the board splint, amputated the leg, put on a permanent dressing and strapped the splint on his leg. When he woke he saw his old sock occupying its usual position. I dressed the leg some ten or twelve days later,

by which time it was entirely healed and it was too late for him to die of fright.

Dr. Stimson kept urging me to use creolin solutions and creolin gauze. I would do so but always returned to bichloride solution. This happened repeatedly. We argued the matter. He insisted that they were getting good results with it at both the New York and the Chambers Street Hospitals. At this time he was visiting surgeon not only to Bellevue but to both of the above. I protested that we were getting still better results with bichloride, which he admitted, adding, however, that he wanted me to try creolin. I said that it caused too much irritation of the skin and of the wound under the continuous wet dressings just then in use. He then *ordered* me to use it. I said, "All right. It is my duty to obey but it is only fair to warn you that, on this matter, you can't trust me *when you are out of sight*."

We looked each other in the eye for a long moment and I think he decided I was a conscientious objector for, with one of his rare smiles, he said, "All right, Macartney, if you feel like that about it, I can be square too. Use the bichloride."

Dr. Gwyer was of a different type in many ways. A slow, conscientious and meticulous operator, careful of details, sometimes hesitant. He was very kind to me, securing my appointment as instructor in Ophthalmic Surgery in the University. Both he and Stephen Smith often took me from the Hospital to patients in private houses and had me do the operative work. It was wonderful training for me since they stood by, advising and directing me. It always seemed to me that Gwyer lost a larger proportion of his operative cases than Stimson because he was slow and the length of time of an operation is a large factor. Stimson was swift but unhurried and sure of himself.

A few days after I left the hospital for good, I returned in time to witness a rather late operation for strangulated hernia. The bowel was released from the constricting ring but, owing to gaseous distention, as soon as one loop of intestine was

crowded back into the abdomen, another slipped out alongside it. This occurred repeatedly and the operator began to sweat profusely and to look around the room rather wildly. With a lot of other surgeons present I did not dare offer any advice but slipped quietly to the foot of the table and asked, "How high do you want me to raise the foot of the table?"

He told me, and there was no further trouble. After the operation was over, he whispered to me, "You did me a good turn. I knew as well as you did that it was the proper procedure, but I was rattled and never thought of it."

Dr. Gouley was a genito-urinary expert. His delicate gentleness and sureness of touch in handling his instruments and his exquisite skill were in marked contrast with his occasional brusqueness of manner. He was not on our division but he borrowed some of our cases one day to supplement his clinical material. On one of these patients he had occasion to pass a urethral sound, but failed utterly after prolonged efforts, finally deciding that nothing but an external urethrotomy would be of avail. After the clinic was over and the patient brought back to the ward, he repeated his decision. I said, "This patient is here for an altogether different trouble. Your own cardinal rule, 'always try a large size first,' you impressed on me so strongly that I am going to try it." With a mischievous grin, I slipped in easily the largest one in our instrument case. He laughed and gave me a cigar.

I was in the midst of a surgical operation one day when a call came to go to the women's ward. I was supposed to give immediate first aid to every accident case, so I rushed to the bedside and, finding that she probably had merely a broken rib, I put a thermometer in this old Irish lady's armpit and told her I would be back soon. On my return, she said with a grateful smile, "Shure, Doctor, that did me a wor-rld of good."

Dr. Cummings, of the medical staff, and I were standing in front of our offices one day when we saw an aged, ragged, and forlorn man toiling painfully up the stair. His beard was

unkempt and stained with tobacco. He was evidently from the purlieus of Avenue A. Purlieus is a word I like. It sounds so sort of er-er-erudite, and I have never had a good chance to use it until now — but to resume: he was a pitiable object. Anyone familiar with the conditions of crowded filth and squalor under which many of these people lived at that time, will wonder how they managed to keep alive. As he neared us, Cummings, who was more familiar with the Scottish claymore than with the delicate rapier, said, "Old man, how long is it since you have had a bath?"

With a transient but unmistakable ptosis of the left eyelid, the old chap said, "Sir, I can't recall off-hand but I have reason to believe I had one eighty-seven years ago, come the twenty-first of next Janiuary."

And it served Dr. Cummings jolly well right. . . .

During my house service we had a severe pandemic of grip. This was in 1889 and was quite comparable with that of 1918. At that time I had three assistants, Dr. Constable, William E. Chase now of Paterson, N. J., and Dr. Rappold of Brooklyn. Constable was on vacation at Old Point Comfort, Rappold was taken with the grip and I sent him home to his father, who was a physician, which left us short-handed. Dr. Chase was capable but comparatively new to the service, so that most of the responsibility and much routine work that would have been delegated to others made inroads upon my time. The hospital was overflowing, immense numbers throughout the city came down with the disease, the doctors who were not likewise ill were sadly over-worked. It was impossible to get outside help.

Then I took the grip myself and was quite ill, with a temperature running up to 103. I wired Constable to come back, after delaying as long as I could, for he needed the vacation. In the interim I carried on as best I could. There was a week that was nearly blank after the peak had passed. I can recall waking during the night, tapping on the crude acoustic telephone and, somewhat irritably I fear, asking the night

nurse why she had called me up without waiting for my reply. When she asserted that she had not called me at all, I would drag myself back to bed, take my temperature and realize, somewhat dully, that I was verging on delirium.

I have a vague recollection of one patient who stopped me on my hurrying rounds and asked me what I could give her to relieve a headache and telling her that if I could rest quietly in bed for *my* headache it would seem heavenly. I have always been a little ashamed of that. Another hazy remembrance is of my standing at some operating table — some operating table somewhere — and feeling quite faint. After an interval, I don't know how long, I told the nurse that, if she would tie a wet towel around my head, I thought I could resume.

Some time later, after Dr. Constable had returned and things were getting righted up a bit, one of the nurses suggested, "Don't you think it is time little Joe should be dressed? It is now ten days since his operation."

"What was this operation?"

"Removal of appendix." We were then quite proud of our appendix operations since they were just becoming fairly frequent. I took off the dressings, found the wound completely healed, and turned to the nurses.

"Look at that for a smooth job. Who operated on this case?"

"You did."

"No. I never saw this boy before." It took some time and the testimony of several present at the operation before I was convinced. Even now I hae ma doots, as the Scotch say.

Later, looking over our records, I found that the mortality for that particular week was about as usual and decided that the kind Providence that looks after fools (and the delirious) must have gotten in His good work.

Often our ministrations were disciplinary as well as curative. Many toughs from the Gas-house gang and other such quarters were brought in by policemen. These cases fre-

quently had scalp wounds from the officer's billy and, since "the law" was still present, the victims gave little trouble. Others came not so attended and, inflamed by whiskey or gin, were more to be feared.

One night while making my midnight rounds, wearing a pair of rubbersoled shoes in order not to waken the patients, I heard some loud talk in the dressing room. Suspecting trouble, I ran to the room and saw a burly tough pinning the assistant surgeon to the floor with a long, hairy forearm. The miscreant was reaching for a four-legged stool to crack the doctor over the head. I struck him under the jaw with all the force of my good right arm and of my speeding body back of it. His head struck the mop-board as he fell and I sat on his chest, telling the assistant to get ready to dress *both* scalp wounds.

One hot summer afternoon, Dr. Henderson, one of the ambulance surgeons, took charge of my wards temporarily and I took his call to a jail up Harlem way to bring in an infected scalp wound to our prison wards. In this way we used to get a little fresh air, free from the hospital smell. The prisoner proved to be a big Irishman with a dirty-looking scalp wound needing attention. Our old horse-drawn ambulances had mattresses for the patient and cross-seats at the rear upon which the ambulance surgeons sat. When we reached a wild and lonely part of upper Central Park, the prisoner made a sudden leap for freedom. I grappled him by the waist and we both fell out of the rear on to the roadway. The driver was an old hand, evidently, for as we struggled, he appeared suddenly with a whiffletree. One hardened criminal soon softened up — in places. Some time later I took a similar trip to the same jail and the warden asked me casually if I had had any trouble with that first prisoner. I said that I hadn't. The warden said, rather incautiously, "He was a bad 'un. I didn't know but he might have tried to get away," thus giving the game away.

I looked him coldly in the eye. "If you knew so much,

why didn't you put the bracelets on him when you put him in the ambulance?"

From these and similar experiences I developed slowly an improved technic. One method was this: Some tough character would come in perhaps at 1 A. M., when everyone was asleep, the long corridors deserted, and the solitary cop on guard at the front gate out of earshot. He would use foul language and threaten us if we hurt him. Usually no one was present but the night nurse. I knew that he could probably do me up in a rough and tumble, that he probably was accustomed to carrying a revolver, but I also knew with what deadly fear such people view surgical instruments and the efficacy of a surprise attack. I would say softly, "My dear sir, kindly remember that there is a young lady present and that she is unaccustomed to such language. It is highly improper to swear in her presence. I don't want to hurt you. I will see what I can do." I would walk over to the instrument cabinet, slip a long, keen, glittering amputating knife under my left armpit beneath my jacket, pick up another instrument and return, saying gently, "There is another thing besides the presence of the lady. You threatened to knock my block off. I really couldn't allow that and [suddenly and fiercely] if you make one false move I will cut your heart into mincemeat," at the same time brandishing the dread instrument wildly in front of his abdomen. I found that some of these tough ones actually fainted.

Newspaper reporters were as a rule very decent chaps, but there were a few that we learned to despise. I said to one of them, "Why don't you write up your interviews in accordance with the facts? Why do you persist in distorting every accident or emergency case into something indecent or horrible? Why don't you tell the truth?"

His answer was, "We don't give a damn for the truth. What we are after is news."

"Then I'll never read your filthy paper again." I warned him repeatedly but he persisted, and at length became so

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obnoxious that I told him flatly what I thought of him. It ended up by my kicking him out of my office. He was a bigger man than I was, but I was much madder than he was. This did not end matters, however.

During the remainder of my service he wrote me up in the columns of his paper to the huge delight of my hospital associates, referring to me as "a rather insignificant individual with spectacles and the sulks," for example, seemingly disregarding the significance of the manhandling I had given him.

He was an adept at skating close to the edge of libel and slander without falling in. The secondary result was not what he had anticipated. People came in from various parts of the city, inquiring for me and seeking my advice, and I profited thereby. They usually prefaced their remarks by stating that they had been reading a good deal about me in the newspapers. When I smilingly suggested that they were referring to the articles appearing in *The Planet*, which were anything but complimentary, they said, "You know we never pay much attention to what we read in the newspapers."

Upon leaving New York, I wrote him the nicest letter of thanks that I could frame, stating that I had paid off all my debts, had a good library with a fine lot of instruments and that it was the direct result of the free advertising he had given me. He was on the whole the cleverest and most monumental prevaricator I ever met.

Matters other than medicine and surgery sometimes occupied our attention. The Board of Commissioners of Public Charities and Correction controlled Bellevue and certain other hospitals in the city, as well as those on Blackwell's and Ward's Islands, these latter designated as the "last place this side of hell." The food furnished the house staffs was execrable. There was rioting at the Islands over this, ineffective, of course. The Bellevue staff sent in petitions and round-robins without avail. A steady diet of bologna sausage will

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eventually pall on most of us. Investigation showed that the appropriation for food for the hospital staff was amply sufficient. It also showed that the amount of gauze, bandage material and other supplies charged up to the hospital was greatly in excess of that actually used. Dr. White had claimed with a straight face that three of his patients developed lead poisoning from the knives used during operations, but, knowing White to be an inveterate joker, we took this with a little salt from the Psalter.

Conditions grew pretty bad and eventually I was appointed a committee of one to interview the Board personally. Armed with a few perfectly authentic records, I appeared before the Board rather unexpectedly and briefly stated our case. They reluctantly admitted that it had been necessary to divert some of the funds for our food to other purposes, but maintained that they were wholly unable to rectify matters. I felt that I held some good cards in my hands. My suggestion that I would interview the Board of Aldermen and the Mayor met only with derision. I intimated that we might even take up the matter through the courts. They countered by insinuating that they could eventually "wind" us in that game, which was undoubtedly true. Then I slapped the joker on the table. "Gentlemen, I hold my position through a competitive examination. The only way in which you can get rid of me is by impeaching me and I will take devilish good care that you secure no adequate grounds for such a procedure. I am poverty-stricken, as you have suggested, but I am hungry and a hungry man is sometimes dangerous. I think I can furnish the public through the *Times*, the *Tribune* and the *Herald* with about three columns of very interesting reading and you may perhaps recall what happened to Boss Tweed." Here I gave them a few perfectly good examples of some things they would hardly care to have published and rested my case.

Their attitude changed. They went into a huddle. They said, "Go back, and if you have further occasion to find fault,

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come and see us again." From then on we had turkey, lobster salad, icecream, fruit, nuts, and a very satisfactory menu. I heard later that after I left the hospital the food soon became as unsatisfactory as before.

My internship in the hospital was one of the most soul-satisfying periods in my entire life. Responsibility, hard work, long hours, no pay, but what of that? I loved it. I had learned to stand on my own feet, to have confidence in my own judgment. I had become philosophic. I had become a fairly good judge of human nature. I had seen so many deaths in the hospital among people of all religions, all creeds, all sects, among Mohammedans, Brahmins, Buddhists, that I respected their points of view and had liberalized my own. I had seen and assisted in the examinations of students who had answered nearly every question correctly but who proved to be total failures in practice. A mind like a phonograph record that will reproduce at will anything once recorded thereon is a poor equipment if not bulwarked by other endowments. I had become familiar with the technic of surgical procedures and reasonably expert as an interior decorator with silver wire and I could even do an intestinal anastomosis with Abbe's rings, superseded later by Murphy's buttons. Though I would gladly have stayed on, my term was drawing to a close. Armed with letters from Loomis, Stimson, Stephen Smith and others, letters which I treasure but which I have never had occasion to use, I sadly took my departure.

Dr. Cummings had never gotten along very well with the superintendent of nurses. Cummings resembled Thomas A. Edison very closely and was a genius, but along different lines. He left the same day I did, and the story was current, but unverified, that he presented a basket of fine oranges to the superintendent together with a note expressing regret that they had not always seen eye to eye and requesting her to distribute the oranges among the nurses. As the story ran, he had injected each orange, by means of a hypodermic syringe, with two minims of croton oil.

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On leaving the Hospital, in lieu of salary, we were given a parchment certificate, like a diploma, a German-silver plate about 1 inch by $2\frac{1}{2}$, suitably engraved, and an order on the instrument makers for \$20 (if my memory serves me right) for such surgical supplies as we chose to select. The little plate, highly prized at the time, still adorns my old instrument cabinet, but I cannot recall that any of my patients during the past fifty years ever took the trouble to read it.

VI

TECHNIC ADVANCES SLOWLY

AT THE time I entered the hospital, ether was the chief anaesthetic, and the old Clover inhaler was in use by many. The ACE mixture of alcohol, chloroform and ether was preferred by a few. Local anaesthesia with cocaine was being used to some extent, its anaesthetic qualities having been discovered by Carl Koller in 1884. The era of antisepsis was on. The carbolic spray of Lister was still used in some wards, but we relied chiefly on irrigating with solutions of bichloride of mercury, Thiersch solution of boric and salicylic acid or other such agents, and wet dressings of various kinds: gauze, oakum, and even curled hair such as was used in mattresses. We were in the pioneer stage, having nothing to work with save the raw materials, unless we make an exception of absorbent cotton, which was of poor quality and not sterile.

This and adhesive plaster were, for all practical purposes, the only commercial supplies obtainable. What was bought in the market as hospital gauze was not sterilized in any way. Most of our bandages were made of ordinary unbleached muslin. We used many sponges, among them large, flat, close-textured elephant's-ear sponges, the latter reserved for abdominal cases. We had no rubber gloves, no masks, caps, gowns, or sterilizers. We were in the experimental stage and each operator, each division, followed a variety of methods, some of them bizarre, others merely time-consuming. Disinfection of the hands and nails and of the operating "field" was usually attempted by various methods and with varying degrees of success. We were still largely in the dark, feeling our way slowly toward the light. We explored many blind pockets, from which we had to turn back, like the

early navigators in their search for a shorter route to the Indies. As in "The Foreloper," "The gull shall whistle in his wake, the blind wave break in fire. He shall fulfill God's utmost will, unknowing His desire." We were sailing an uncharted ocean but we knew what we were headed for in a general way and we were undoubtedly fulfilling His will.

Abdominal cavities were being deluged with immense quantities of antiseptic fluids. One of our best operators wore high rubbers or rubber boots with rubber aprons during his abdominal operations. Operating tables were arranged to carry away the overflow of excess fluids. Our methods were sloppy — sloppy in more senses than one. But we were reasoning logically, working earnestly, picking up here and there bit by bit ideas or mere hints, patiently matching the pieces of this puzzling problem until at length, on the First Surgical, we got results which we deemed satisfactory. I have still a list of 200 consecutive "clean" cases, and by clean cases I mean operations for cure of hernia, removal of morbid growths, for unruptured appendices, amputations, wiring fractured knee-caps and various operations where no infection was already present to any extent. These were unselected cases otherwise, and we had in the 200 cases only four in which infection developed, or exactly 2 per cent. Such a record would be regarded even today as good.

It proved that our methods were becoming effective. To my mind at the same time, the four failures proved rather more than our 196 successes, this because we could furnish an entirely logical explanation for our four failures, three of which were accidental. A brief description of what occurred will make this clear.

One was an operation for removal of a cirroid aneurism of the left temple, a bloody and tedious operation during the course of which the operator put his finger in the patient's mouth to bring deep tissues within reach and then, unthinkingly, put the finger back into the wound. I called his attention to this lapse and we irrigated the wound while he

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was disinfecting his hand, but we had a slight infection with approximately a teaspoonful of pus in all.

The second case was somewhat similar, but almost entirely accidental. We were operating on a lower jaw which had sustained a double fracture and had been so badly set that the teeth could not be brought in apposition. We cut down on the ramus below the joint on one side and with a chisel, refractured it; then turning the patient on the opposite side, we went through a similar procedure, during which time a "gum boil" on the chin, originating in an ulcerated tooth and hitherto unnoticed, had ruptured, some of the pus gravitating into the wound underneath. We had a slight but unimportant infection, chiefly notable for the peculiar odor of the pus, which was that of a decayed tooth.

The next was an excision of the astragalus in a bad case of club foot. Stimson wished to have a curled-hair dressing used on this, experimentally. The nurse assigned to prepare this was taken suddenly ill and another substituted. Thinking, from the label, that this hair had been disinfected, she included it among the other dressings and unwittingly it was applied in the raw state. When a slight infection occurred we made an investigation which revealed the above facts.

The fourth case was not accidental. During my temporary absence the senior assistant substituted for the catgut we had been using, some prepared by himself in a different manner. The wound healed well save for two small stitch abscesses.

At this stage of the game we were disinfecting and bleaching our sponges with chlorine and, in some cases, using gauze mops as a substitute for the sponges. Our hands and fingernails were cleansed and disinfected by soap and water and a nail-brush, followed by immersion in bichloride solution, or a solution of permanganate of potash followed by one of oxalic acid. When our hands got too sore we shifted temporarily to carbolic or some other germicide. The field of operation was prepared in a similar manner: Soap and water,

sometimes followed by alcohol or ether, but almost invariably these preliminary measures were followed by bichloride. The instruments were boiled if they would stand it. If some of them were of the older types and had wooden handles, etc., which would not stand boiling, we were forced to adopt other methods of disinfection which varied as occasion demanded.

During the latter part of my service, linen jackets came into use in a limited way. They were ready-made short jackets such as the barbers were using, and we bought these as our personal funds would permit. Our aprons were chiefly rubber ones. I recall the first time I appeared in the big amphitheater with a white jacket. It was some head operation and I was shaving the head preparatory to operative procedure. Someone started the cry, "Barber! Barber!" and soon hundreds of students took up the shout. Knowing that the nickname would stick readily, I apparently took no notice, save for strapping my razor on a towel, rubbing in the lather with somewhat exaggerated flourishes and quietly saying, "Next," when I had finished. That was the last I ever heard of it.

Our plaster of paris bandages we prepared from the raw plaster and strips of crinoline cut to required width. It was a mussy job. We had bichloride gauze, carbolic, boric acid, Thiersch and iodoform gauze which we taught the nurses how to prepare or assisted them in so doing. The hospital gauze, so-called, was absorbent, but not sterile, cheese-cloth. It was soaked in the appropriate solution, wrung out, folded and carefully wrapped in disinfected oiled muslin, then each roll was labeled. Iodoform gauze in various strengths necessitated a little different procedure, the solvent being usually ether. This dried out quickly but the odor remained on our hands and clothing for an indefinite period. Sterilization by baking was understood but was seldom used since we had no facilities in that line, and steam sterilization under pressure was unknown.

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Silk-worm gut sutures were boiled with the instruments. Silk sutures were thoroughly boiled, then immersed and kept in bichloride solution. This would eventually rot the silk, but our service was too active for this to be of much moment. That this method was effective I can testify, for we never hesitated to use it in tying off the pedicle of an ovarian cyst or the base of a hernial sac, and forgetting it.

At that time we were frequently accustomed to do, instead of the open method of wiring a fractured knee-cap, a subcutaneous ligation of the knee-cap, passing a heavy silk ligature the size of a trolling line through the tendon of the great thigh muscles above, down close to the patella, through the ligamentum patellae, up the other side and returning to the starting point. The fragments of the patella were forced in close apposition, the ligature tied tightly and the knot buried in the original small puncture. We never had the slightest trouble from it. The results were satisfactory.

We tried control experiments. I recall one woman who was badly injured and who was in the hospital for a very long time. Among other injuries was a crushed little finger which I amputated. For a period of four months I left in a number of silk sutures, which were partly in the finger and partly in the open air. There was not the slightest sign of irritation from these sutures. Had she been having her hands in dishwater three times a day, such a result would naturally have been impossible.

The fact that I am still preparing my silk by this method when I can buy such material from the surgical dressing houses more cheaply than I can prepare it myself, proves that the method is satisfactory for my own purposes.

Our catgut was purchased as violin strings. It was soaked for months in oil of cedar and kept in an alcoholic solution of bichloride. It made very good material but newer and more scientific methods have given us a better and more uniform product. I have not prepared any catgut for a great many years.

My mental processes were such that I was never prone to follow a rut blindly and, from time to time, I was personally responsible for many of the changes in our technic. I strove in every way to simplify it because, with our human limitations, I felt it to be impossible to follow closely a large number of things at one and the same time; in my case at least.

We disregarded atmospheric germs, abandoned the carbolic spray and placed strong emphasis on the care of our hands and fingernails. We felt that the phagocytes were able to take care of the few germs from the air, but if we rubbed in germs with our fingers or instruments, if we carried them in from a skin that was not properly disinfected, we were riding for a fall. This applied to our sponges and pads. Above all, we insisted day in and day out, with all the emphasis we possessed, that ligatures, sutures, drainage tubes and packings be above suspicion, since they were actually imbedded in the tissues and, in that sense, the most likely sources of infection.

In this connection I may quote from an article I published in one of the medical journals during my hospital service. "Ligatures and Sutures:—There are a few points in connection with these articles which are frequently overlooked. In nine cases out of ten when, after a supposed antiseptic operation, pus is found in the wound, the ligatures or the sutures are the cause. Healthy tissues will stand momentary exposure to infection, but prolonged contact with infected catgut or silk will produce pus invariably. Suture abscesses are still unfortunately too common and always point to infected sutures. With properly prepared sutures such an abscess should never occur. Silk is best kept in aqueous solution of bichloride 1/500. Catgut in an alcoholic solution of bichloride of the same strength. Such silk can be safely left buried in a wound for life and external sutures thus prepared have been left untouched for four months, experimentally, without producing the slightest irritation or ulceration. For operations

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in regions which are naturally moist, such as the axilla or perineum, silk is not well adapted, owing to its tendency to absorb the moist secretions from the surface, and carry them into the tissues by capillary attraction. Where the surface of the wound cannot be kept dry and free from all septic contamination, silk sutures ulcerate out rapidly. Here silk-worm gut or wire is preferable. . . .”

Dressings of wet bichloride gauze or similar wet dressings were in high favor. We were considered reckless because, long before our associates adopted them, we were habitually using permanent dry dressings which, to use their phrase, “could not kill the germs.” We fought sturdily for these things and, since the surgeons were all watching each other’s methods closely — the whole thing being still in its formative stage and constantly subject to change — it soon got about that we were getting some astonishing results in the First Surgical. Surgeons of note from the other divisions, from other hospitals, other cities, came in numbers to watch our methods. I think that a majority of them wholly disapproved of our technic. I know that many of them did not hesitate to manifest their disapproval. I endeavored to explain to them, when they condemned our seeming lack of meticulous detail, our dry dressings, that while germs grew readily on moist boiled potato, at that time a common culture medium, they did not thrive on a Saratoga chip; that, confronted with a difficult problem, if it were stripped of its non-essentials, reduced to its simplest form, if we blocked off all side issues and confusing blind alleys, the problem clarified itself. When some of my critics became too insistent, I fear that I shocked some of them by saying that there were two ways of nailing a board horizontally to a fence with a post at each end and one in the center. One method would be to put a nail in each four-inch space. The other was to drive home three nails in each end post and three in the middle, thus not only saving time, nails and muscular effort

but achieving better results. Certain victims of intellectual vanity were indignant at such a rude comparison.

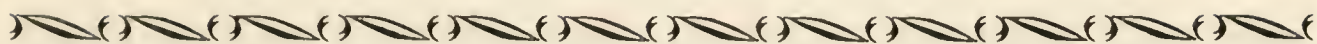
The visiting staff, Stimson, Stephen Smith, and Gwyer, rode me with a light bridle-hand and granted me much freedom of action for which one Scotch-Irishman was truly grateful. Quite a few years after I left the Hospital I was treating Charles Denneen, a young lawyer, for an obstinate trouble. He moved to New York City and I gave him a letter to Dr. Gwyer. The following summer he was home on a vacation and came in to see me.

"Well, I saw Dr. Gwyer, gave him your letter and told him you had referred me to him for continued treatment. The Doctor read your letter through twice and seemed a bit puzzled, saying, 'Macartney — Macartney. I don't just place him.' I told him that you had been an interne in Bellevue under him. He brightened up and said, 'You know these young doctors are coming and going all the time and after a dozen years or so, we remember only the very good and the very bad ones, but I remember Macartney very well indeed.' He took good care of me and fixed me up all right."

"Did he specify in which of the two classes I belonged?" I asked with a twinkle of amusement.

Charley shook his head.

At the time I left the Hospital in April, 1890, antiseptic as distinguished from aseptic surgery, was predominant. The latter, however, was showing signs of embryonic life and, in 1892, was ushered in largely through the teachings of Von Bergmann and others. It had been a long, hard road from Semmelweiss and Holmes to Von Bergmann but one which I was privileged to follow with extreme interest.

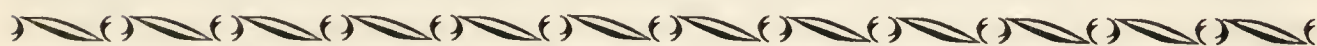


VII

THE HOMING PIGEON

“In the sweat of thy face shalt thou eat bread.”

Genesis iii, 19



AT THE time I left Bellevue I intended to settle permanently in New York. I was on the eligible list as surgeon in one branch of the public service. I could have gone to Panama as surgeon under the old canal company, or to Arkansas as surgeon to a third-rate railway. Duty decreed that I return home. My parents were getting old and needed me. So I came back to the town where I was born, a village of some 800 inhabitants in northern New York, on the Canadian border. Here I had gone to school, clerked in the local drug-store; being merely one of the town lads is always a serious handicap to the young practitioner. At the end of eight years my father and mother had passed on. There was no longer any good reason for remaining at home.

The little village had always been, in a way, a medical center for a large farming section, and I had found no lack of work. I had ample funds on hand to maintain a good office in a favorable location in the city for at least two years, at the end of which time I thought I would be able to make headway. So I went back to New York City, spent some weeks looking the field over, visiting old classmates and hospital associates. I gave the matter careful thought and, in the end, deliberately chose to return to my country practice. I have never really regretted my decision, though I am not recommending this course to others. It is all a matter of taste. I think that the impelling motive was that I had learned to love the people, my patients.

Horses were then the usual means of transportation. I

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had three which I used alternately, as a rule. I chose light, swift-gaited ponies, Veto or Legacy by preference, driving with a loose line and open bridle, teaching them to turn out for other teams, to stand without hitching. They became wise, trustworthy, and as affectionate as dogs. I could always get along with a balky horse. A soft voice, a gentle manner and kindness, instead of the loud command and the whip, worked wonders. I had enough balkiness myself, so I understood.

I had a Concord buggy, a light two-wheeled cart, saddles and saddle bags, a cutter and a pung or berlin for winter, a bicycle and motor boat. With this equipment I averaged from 12,000 to 14,000 miles per year. Given a good road and my two-wheeled cart I could travel 12 miles an hour and frequently did so in a pinch. I fed my horses oats (no hay), a little oat straw, and consequently their wind was good. I drove one pair on the road for seventeen years. I was often amused on coming out from a hotel in some distant town to have the hotel hostler ask me if I were Dr. Macartney, adding, "I thought so. I've heard so much about that little team."

I learned to form opinions of people before I ever entered the house. If there was a mudhole in the middle of the gateway and no hitching post or ring, they automatically classified themselves as lacking consideration for others.

In those early days it was the winter custom, in our locality at least, for many of the men and practically all the physicians to wear a large shawl woven from native wool on some hand loom. This was folded length-wise, wrapped around the waist, crossed suspender-wise at the back, the ends being drawn over either shoulder and tucked beneath the belt part in front. It was warm and comfortable and could be worn while riding a saddle horse. In severe storms of rain, sleet or snow it could be unfolded, thrown over the head and pinned at the throat and chest by two large safety pins with which it was always provided. In many of the houses where

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I had to spend the night there was no extra bed or couch available. Here I would assemble a line of straight-backed kitchen chairs, place them in a row and spread half of the heavy shawl on this improvised cot, lie down on it and throw the other half over as a cover. This was far safer than trying to sleep on a cold floor, and by alternating the position of the chair-backs I avoided the risk of falling out of bed during such cat-naps as I secured. Needs must when the devil drives.

The winters were the worst. Though born here in Fort Covington, I always suffered from the severe cold, never getting really hardened to it. I had a little English beagle as a foot-warmer, cuddled between my feet under my fur robes. I had a patent foot-warmer but never used it. Mike was always ready, always lit, never went out, never burned the blankets, carried his own thermostat, and he just loved it.

On many a wintry night I got lost when there were no tracks, or the tracks were drifted over and the blizzard blotted out all landmarks. Occasionally I would have to tie my horse to a near-by fence, cover him with a big buffalo-robe and continue my journey on snowshoes. I recall such a night when my pony, exhausted by long battling with the drifts, fell, and was unable to rise. I covered her carefully with robes and my fur coat, and started through a sugar-wood for the nearest farmhouse some half-mile distant. I floundered through snow deep enough in places to reach my shoulders, burrowing down in it from time to time to escape the bitter wind, get my breath and warm up, then pushing ahead. At length I got within some ten rods of the farmhouse but could go no further, having no snowshoes with me. I was all in. Many a sincere prayer is sent up by a man not on his knees but standing with his head unbowed. The farmhouse door opened and two men came out on the way to the barn. I yelled, and the wind being favorable, they heard me, came with their lantern and dug me out. They helped me to the house and as soon as I got fairly warm I piloted them back to my horse. I went about a mile further on my homeward way

but, encountering an impassable drift, spent the remainder of the night at another farmhouse.

There was a happier side, however, to the work in winter. One brilliant Christmas morning I was coming home through a "winter road" between two stretches of wood. I noticed some small animal crossing ahead of me. The snow was so deep and soft that he was making slow progress, having to jump high in order to clear the snow and burying himself in it at the end of each leap. He looked dark against the sunlit snow and I thought he was a mink, that fiercest and wickedest of our small mammals. Stopping my horse and taking my whip from the socket, I overtook him just as he reached the second wood. He managed to run up a small maple sapling to a height of about five feet and there faced me through a crotch of the sapling, teeth bared. He was a gray squirrel. I stood there with the butt of the whip in my hand and saw him face death unflinchingly. He was panting with his exertions and his skin showed crimson where the wind parted the fur. I watched him for a moment, took off my fur cap, bowed to him and said, "I wish you a Merry Christmas." I hope he understood.

One sleety November day I got a call to see an old Yankee farmer living on "Sand Street," an out-of-the-way place. He was having a heart attack. I hung up my rubber coat, put my gloves on the warming-shelf to dry and came over to him immediately. I found that in changing my clothes that morning I had left my stethoscope in another coat. I began opening his shirt in front, encountered a second one and, seeing still another, said, "How many shirts are you wearing, Abner, six?"

"No," said he, "I ain't got only four on."

Finally I got my ear down to his chest when his wife appeared from the "buttery," saying, "Abner, why don't you take off some of them shirts so the doctor can hear what is goin' on in your insides?"

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Abner grinned. "Oh, the doctor, the doctor. All the doctor's trying to do is warm his ear."

Occasionally I had some student or newly fledged doctor to assist me, but usually I had to manage as best as I could, meeting each difficult situation as it arose. I always laugh when I think of one Paul Proulx, a strong, tall, vigorous French-Canadian. He and a neighbor, Jimmy Anderson, coming home one night well plastered, overturned into a deep ditch and I was called to reduce a dislocated elbow. He was in a fighting mood and, when I would approach him, he would brush me aside with one sweep of a long, muscular arm. I knew it would be impossible for me to give him an anæsthetic single-handed, and it was unlikely that reduction could be effected without it, owing to his rigid and powerful muscles. There was no telephone available. To send for another doctor meant waiting indefinitely, since a messenger would have to be sent six miles over frozen and rutted roads, and besides, there was no one to send, and quite likely no doctor available.

The uninjured man was hovering around and constantly getting in my way, so I sat Paul on the side of the bed and, holding the wrist of his injured arm, asked Jimmy to get on the bed behind him and hold him tight by the waist. Thus I sat for a while, idly swinging my patient's arm gently from side to side. Suddenly the farm dog barked. "What's that dog barking at?" I inquired with some show of excitement. Paul's attention was momentarily diverted, and taking advantage of his temporary relaxation, I struck a swift downward blow with the flat of my hand just below his flexed elbow and the bones slipped back into place. The funny part is that Jimmy never met me afterwards but that he said, "Cripes, Doctor, but didn't we do a good job on Paul Proulx?"

I had much surgery to do, both minor and major. A bed is ill adapted for a surgical operation. I commonly used a kitchen table, supplemented by a small stand or two. Having no antiseptic tablets, I carried with me a 50 per cent solution

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of mercuric chloride in glycerine, colored with aniline for safety's sake. Unable to get anything suitable for gauze material, since cheese cloth was non-absorbent, I used old but clean linen tablecloths supplied by friends. These were cut to convenient sizes, soaked in bichloride solution colored pink with eosin and wrapped carefully in oiled silk or muslin. I was amply supplied with instruments, with self-retaining retractors, etc., and, thus equipped, opened abdomens, operated on hernias, mostly strangulated, appendix cases and similar acute conditions. The wounds healed promptly and my results were, in the main, very satisfactory.

In emergencies and when during the course of some operation some extra instrument was needed, I soon learned to pour alcohol in a saucer and flame it thoroughly but quickly, thus avoiding time-consuming boiling.

I had a volvulus case, a young teacher in an adjoining town. This was one of the cases that taught me how easy it is to unravel a stocking if you begin at the right end and how difficult or impossible it may be if you start from the wrong end. We got the intestinal knot relieved when we went at it the right way and she made an uneventful recovery. In this instance I had two other doctors with me, one of whom was a bit disputatious. I was using a biniodide of mercury soap for the preliminary disinfection of the abdomen, when the following colloquy ensued:

"Are you sure that this soap kills the germs?"

"Yes."

"How do you know?"

"I've used it for many years and it works."

"But will it kill the germs?"

"Yes, it kills the germs."

"How do you know it kills the germs?"

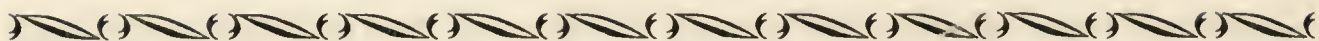
"Well, I know it kills fleas on dogs."

Archie McCann had an ear nearly torn off and I sutured it back in place. Some three weeks later a neighbor of Archie's came in and asked me to go down to Archie's place and fix

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his ear. Somewhat startled, I asked what had gone wrong with the ear.

“Nothing at all. Nothing at all. It’s his right ear we want you to fix. He carries the left one you sewed on so much better.”

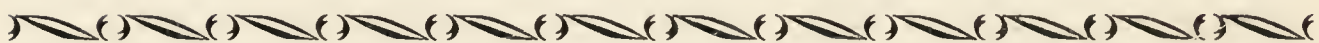


VIII

DOCTOR JENKINS

"I pray your Highness mark this curious herb."

LELAND



DR. JENKINS was a tall, gaunt, bearded, bushy-eyebrowed, quizzical old physician. With most of his patients he was kindness and gentleness incarnate, but with those who lied to him or who wasted his time needlessly, he had little patience. I heard him tell one woman (who had nearly blistered his ear-drums with foolish chit-chat and who at last said, "I'm afraid, Doctor, that you may think we women talk too much"), "It isn't your talking so much but your saying so little that gets me."

Women used to ask him fool questions, such as, "If we send little Billy to the sanitarium as you advise, I want you to tell me just how long he will have to stay there before he is completely cured."

His answer would be, "How old is Ann? How far is it from here to there? What's the distance from to to fro? How long is a piece of string?"

One day we drove twenty miles into the county of the "Fighting O'Haras," a quarrelsome lot. We came to a piece of turnpike which was entirely destitute of snow and we got out and walked a quarter of a mile for the sake of the horse. On our return we noticed that there was a single cutter track running through an unfenced pasture along this bare strip of road-bed. We slipped along easily through the pasture stubble and thought little of it, for we had taken down no fences, were not scattering thistle seeds, were making no impression on the frozen ground, were not even starting a new winter road since, save for an occasional stranger, the people were

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all driving wagons. As we were nearing the place where we would turn back on the main road, a man rushed out of the farmhouse and shouted furiously, "I should think that a man in broad daylight would have sense enough to follow the main highway instead of trespassing on other people's property."

Jenkins said quietly, "If this is your property and we've done you any wrong, we'll gladly undo it as best we can by driving back and getting off where we got on."

"Get off here. The quicker you get off the better it will suit me."

Jenkins said, after throwing back the buffalo robe, removing his overcoat and getting his feet outside on the cutter-rail, "Come here a minute."

"What do you want?" asked the man suspiciously.

"Oh, I just want to visit with you, to get acquainted with you."

Warily the man came closer and Jenkins handed him a dime. "What's that for?" the man asked.

"I owe you six cents for trespass but just keep the change and I'll trade it out next time I come."

"Con-demn you, I'd lick you for less than six cents," growled O'Hara.

Jenkins stood up and said, "My friend, I'd like awful well to accommodate you but this is the Sabbath day, which, up here near Canada, we are taught to keep holy, and besides I promised my dear old mother years ago that if I ever let any man lick me, it would be a large, handsome, nice-looking man and you don't fill the bill, because you look to me like the most white-livered, flea-bitten, warty-nosed specimen of a two-legged skunk that God has ever permitted me to view." The man's hands clenched, he frothed a little at the mouth, but he simply stood and took it as we walked our horse slowly and deliberately off his "property."

One day he confessed to me, "I told a darned good lie a while back. If I had told the truth, the husband would

have left his wife and a bunch of innocent kids would have been disgraced. My reputation for telling the truth was pretty good so I looked him in the eye and lied straight. More'n that, he believed me. If I'm to be punished for it hereafter, I hope I'll be man enough to take it without whimpering. But I scorched the soul of that woman a few days later when I got a chance.

"And the other day a nice old lady came into my office and said she had a little tumor in the middle of her back and it was getting sore. I found a big, fat woodtick there. It didn't take me a minute to remove it and drop it in the slop-jar, but I charged the usual office fee and told her that it would never trouble her again. Might have showed her that tick but she was a nice old body and it would have mortified her most to death."

One time when some of our Navy lads got us into a little mix-up with Mexico and complained that the Mexicans had insulted our flag, a big farmer from the south part of the town was telling a lot of people in the post-office that we should send a few regiments over into Mexico to teach those blamed greasers to behave themselves.

Jenkins asked him if he had ever been in Mexico, if he knew anything about the kind of guerilla warfare our lads would be likely to encounter, or how many would be killed, crippled and mutilated, if he had any idea of how much bloodshed would follow. Not getting anywhere with the fellow, he exploded, "You're a nice one to talk about war. Why, last winter when your neighbor's boy got the end of his thumb cut in a circular saw, you got so faint you couldn't hold a basin for me when I was dressing the cut."

One summer night he needed a nurse badly and rang the doorbell of a certain young nurse. She opened the door about an inch and said to him, "Would you mind waiting on the piazza until I get some clothes on."

"Young lady, you needn't be so particular. The first time I saw you, you didn't have a darned thing on."

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When some small boy was brought to his office for treatment and was evidently scared stiff at the sight of the instruments, he would sit beside him and say cheerfully, "Pshaw, that's nothing. Just a hickey-madoodle and two doo-dads."

Someone would complain of a pain in the lower left quadrant of the abdomen.

"That's a good place to have a pain. There's nothing much there."

Once we were witnesses at Malone, on a murder trial and, while in the hotel office, a man was loudly proclaiming that he had a saddle horse that was a wonder and that he could ride him from Malone to Fort Covington, a distance of sixteen miles, in less than an hour. An incredulous bystander asked Dr. Jenkins if he believed this. The doctor said that he knew nothing of the horse referred to and was not interested in the discussion. The skeptic persisted, however, and the doctor finally said,

"If it is merely an academic question of whether it is possible to ride a horse sixteen miles in an hour and it has no reference to anything previously said here tonight, I might venture an opinion that there are, possibly, two ways of doing it."

"What two ways?"

"One way would be to get a fine saddle-pony, a light driver and a cool day, then ride him the sixteen miles under whip and spur and hire Jim Bejin to bury him at the end of the trip."

"What is the other way?"

"Simpler still. Just sit around the Franklin House and tell about it."

On another occasion he was called to the Northern Hotel and met another doctor who was just leaving the hostelry. As Jenkins was passing through the lobby a local tinsmith said,

"Doctor, how many calls did you ever make in a day?"

"During grip epidemics, when I had a bunch of patients along a few streets, perhaps twenty-five or thirty," said Jenkins.

"But one doctor recently told us that he had made sixty-nine calls yesterday, with a horse and cutter, many of the calls in outlying districts. Do you believe you could make that many?"

Jenkins nodded.

"How in thunder could you do it under these conditions?"

Jenkins drew a dog whistle from his pocket. "No trouble at all if I set my mind to it. Just take my little Boston terrier along and call him sixty-nine times. Such calls are mostly wind."

Underneath all this he was essentially kind. During a severe grip epidemic he took a friend with him on his daily round. On coming out of a farmhouse he met with a slight accident due to a doorway somewhat cluttered up and in need of repair. His companion said, "Wouldn't you think they would keep their doorway in better shape? You might have been seriously hurt."

He quietly said, "The mother and father, with all their young children are all in bed, seriously sick. The hired man and the hired girl are both upstairs with the grip. They have been unable to get a nurse. An aunt who came here to look after them is down with it. The neighbors are milking their cows, doing their chores but are afraid of the disease and do not enter the house, simply leaving milk, water and a supply of stovewood on the door-steps after which one of the sick gets out of bed and manages somehow to bring in the supplies. The condition of that doorway, at present, probably is the least of the troubles with which that family is afflicted."

Charity covers a multitude of sins. Judge not lest ye be also judged. We are prone to look down upon the Zulu or Matabele warrior as a heathen and a primitive savage, despising him because he clothes himself lightly in a discarded shoe-string, arms himself with a rhinoceros-hide shield and an assegai, because he wears a few pounds of copper anklets and a brass ring in his nose. Being charitably inclined, and, having given the matter due thought, I am firmly convinced

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that if approximately 50 per cent of the people in the United States (males, mostly) wore a good stout ring in the nose, they would be more amenable to persuasion—of a sort. It may well be that these tribes, having tried out other methods, have found this not only simple but efficient. Dr. Jenkins had charity.

He was human, however, and his charity had limitations. One spring morning he was called to see a sick woman across the Canadian border. The front yard was littered with rubbish; the beds, chairs, tables and other furnishings broken; the filth indescribable; there was neither wash basin nor anything that would serve as a towel. He had occasion to leave some medicine which would decompose in contact with metal. He tried to find a glass, an empty jelly or fruit jar, a bottle, a milk pitcher or a crockery cup. There was nothing but some battered tin plates and cups and some broken whiskey bottles in the yard. Finally he found a saucer with a big notch broken out of its rim. Propping up the broken edge with a chip he put the medicine in this receptacle after washing it as clean as possible. As he was leaving the house he met a woman coming from a near-by farmhouse, whereupon the lady said, "Isn't it awful that these people are so destitute?"

"Isn't it awful they are so dirty, so lazy, shiftless and drunken?"

"But you know, Doctor, they are awfully poor."

"They always will be. When they get a dollar they both get drunk and smash all the furniture and throw the dishes at each other. There is a brook running right by the house. They could at least keep clean."

"But I don't suppose they even have money to buy soap."

"If they had ambition enough to wipe their own noses they could make soap. There are at least five bushels of wood ashes right here in the front yard."

"But, Doctor, where would they get the grease?"

"Scrape it off themselves. They're covered with it," snapped the doctor as he stalked off to his buggy.

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One of his favorite remarks was, "It's a good thing to have something on your mind besides dandruff." He applied this in many ways.

On one occasion he picked up the Bible and said, "Aside from certain begettings, the entire history of Methuselah seems to be summed up here [reading from Genesis, V. 27], 'And all the days of Methuselah were nine hundred sixty and nine years; and he died.' " He remarked, "If some of us doctors could live that long, I believe we could accomplish more than that."

He would take a long pull on his cigar and drily remark, "When I first came here we had three industries: barrel-hoops, straw hats, and babies. Two of 'em are now extinct." On a later occasion, when our population had been increasing with unusual rapidity, he said, "If you're still the health officer in your district, take my advice. If there are any old maids down your way, shut 'em up this year."

He had an argument with a local believer in vegetarianism. One of the points he scored was, "How do you know a head of cabbage doesn't want to live just as much as you do?" Another was, "If it isn't right to take life, we have no right to destroy the germs of malaria. Why, man, just carry out your theory to its legitimate conclusion and within ten years you'll be the lousiest (and busiest) man in Franklin County!"

During the suffrage campaign, some women from the county seat held an open air meeting after nightfall, speaking from their automobiles. Jenkins was asked to introduce the speakers, which he did. Dr. W. H. Kingston, of Hogansburg, came to the meeting with his wife, who was very much interested in the suffrage movement. On arriving in town they found one of their own hens asleep on the running board where she had gone to roost. After the close of the meeting some of the local politicians kidded Jenkins about his introducing the suffrage speakers, asking him when he had left his own party and joined the suffragettes. He answered, "Gentlemen, when a plain, ordinary barnyard hen, with a

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brain the size of a kidney bean, will steal a ride on a tin Lizzie and travel nine miles after dark to attend a suffrage meeting, it is high time that you read the signs and either come into the suffrage camp or hike for the tall timber where you otherwise belong."

A few days later he went into the Registrar's office to file a birth certificate. The Registrar, one of his hecklers on the night alluded to, recognizing the document, said, "What's this one, Doctor? A Republican or a Democrat?"

"Wrong as usual, George. This is a suffragette," he replied.

The doctor's brother never failed when he was at a party or a big dinner, with Doctor and Mrs. Jenkins present, to tell the following story which actually occurred much as he related it. Jenkins and his wife both seemed to enjoy it thoroughly.

A very fine Canadian couple moved into town from Quebec. They were nice people in every way, but Mrs. LeRoy's English, while fluent, was not perfect. She came into the store one day leading a little girl by the hand. The doctor's brother (who tells the story) said, "How old is your little girl, Mrs. LeRoy?"

"Half-past six."

"I hear you have a new baby over at your house."

"Yes," (beaming with delight).

"You must have a nice family by now. How many children have you?"

Smiling still more happily, this motherly and amiable woman said proudly, "Fourteen, all healthy. Six of them I have in Quebec before I come here and all the rest by Doctor Jenkins."

A patient with a serious brain lesion was being taken care of by the doctor and, from New York City, a very noted specialist in cerebral localization, was called in. Together they worked over him for two days, and as the expert was taking his departure, Jenkins said to him, "Dr. X—, if you will tell me what treatment you want carried out in this

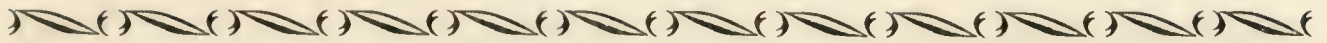
case, I will promise to follow it as closely as possible." The specialist looked at him soberly for a moment, put his arm around Jenkins' shoulder affectionately and said, "Doctor Jenkins, if you will come and see me some time in my hospital in New York, I can show you some interesting and instructive brain cases. There I have a staff of assistants and nurses; all the laboratory facilities available, expert counsel at my command. I came up here and I felt helpless. You saw it, sterilized a catheter and my needles for spinal puncture on the kitchen stove and helped me skilfully. I had no question in my mind about their being absolutely sterile and everything in order. Tell *you* what further to do in this case? Not on your life! You are in full charge, and please take this in the right way,

"By the living God that made you,
You're a better man than I am, Gunga Din."

Did that lessen the specialist's stature one cubit? It only proved what we had already learned, that he was a man worth while.

One time Dr. Jenkins was coming by train from Plattsburg to Malone. The engine got out of order and they had to stop over for some two hours at a little village in the huckleberry region. The passenger all went up to the one-horse hotel. One of them, recollecting that an old schoolmate lived in the hamlet, went into the hotel office and saw a man whom he took to be the proprietor, sitting at a table with his chin in his hands gazing intently at nothing at all. Touching him on the shoulder he said, "Excuse me, but can you tell me where Eb Larkin lives?"

Dr. Jenkins turned to him and said soberly, "Sorry, but I'm a total stranger in this place and I'm damned glad of it."



IX

NATIVE AND NEIGHBORING BIRDS

“He who knows nothing doubts nothing.”
—*Old Italian proverb*



I HAD to go down to the garage to get oil changed. Uncle Eph's breast feathers and tail coverts had the characteristic mottlings of his genus and species, black and brown on a fawn-colored base. In his gossipy way he kept up a monologue as he assembled the “innards” of an ancient flivver:

“Si Perkins's wife and Dr. Jenkins hed a little run-in yesterday. She was in one of her tempers and was takin' it out on the doctor 'cause he happened 'round and Si hed cleared out, temporary-like. Jenkins jest sat there and kidded her and she was gettin' madder and madder. Finally she got real mean, got her spark advanced till her engine began to knock and she says, 'Ef there's anythin' I hate it's to see anybody with whiskers all over their face.'

“Doc, he jest settles back in his chair, fills up his old briar and says, 'Ef I was you, which I ain't, I wouldn't worry about that. Far as I can see, you ain't likely to grow any of your own and I'm danged sure you won't ever have any of *mine* on your face.' With that she got so bilin' mad she whipped out with her skirts a-flyin' and slammed the door on him. He's the only one I know that can get along with the old vixen. Don't know how he does it 'cept he jest out-devils her.

“Business? We-ell, it ain't half bad, not for fellers that's willin' to work. Seems to me there's jest about so much work to do, year in and year out, and someone hez to do it or we don't get nowhere. Trouble is jest now we're helpin' too many shirkers and discouragin' too many workers. Life looks

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to me some like one of these here big railway terminals like you see in New York and Chicago and sich places. Acres of tracks set down 'cordin' to regular pattern and pinned down with spikes. Big Mogul and Corliss engines; heavy duty and swift passenger locomotives; small switchin' and donkey engines; little hand-cars and baggage trucks run by gasoline. Then there's big private cars, Pullmans, mail cars, box and refrigerator cars; flat and tank cars and all sich. Seems as though you could line 'em up in two classes. Them that has their own motive power and, besides, do all the pullin' and pushin' fer the whole caboodle. The others jest sit on the tracks and wait to be shoved or hauled around. Only time I ever see one of *them* git a move on, all by themselves like, is when it's left on a grade with the brakes off and when it does move thataway, it's always *down grade*. More'n that, when either kind wants to get somewhere, looks to me safer to foller the reg'lar system of tracks and switches than to go cross-lots to make a short cut in a hurry. It makes rough goin' for either an engine or a freight car when you try *that* plan besides messin' things up a whole lot and leavin' someone to foot all the bills.

"The minister was in the other day. Must have had a blue spell, like we all have at times. He says, 'If it wasn't for the women, with their chicken dinners and picnics and socials and all, the churches would be in a bad way.' Doctor Jenkins happened along jest then and they got to arguin' about it. The minister says, 'Who makes up the bulk of our congregations, tell me that? Mostly the women and children. How many men come to prayer meeting Thursday nights? Who teaches the children their Sunday-school lessons? Who does all the praying for the family and teaches the children to say, 'Now I lay me'? And who does all the swearing and cursing for the family? The men.'

"'True enough,' says the doctor, 'But who furnishes the cash to build the church in the first place? Who pays the

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pew rents and your salary? Who foots the bills for janitor and coal and lights? The men.'

" 'But you don't understand,' says the minister. 'I'm at the head of the church affairs and I mingle with my people and I know. Women are just naturally better than men, more gentle and kind and sympathetic; more religious and devout.'

" 'I mingle quite a bit myself,' says Jenkins. 'I see lots of folks in the middle of the night when they are wild with grief, terror and suffering, when they aren't thinking of what people may say. I see them in the raw, as they really are. You take tea in the afternoon with the women, generally when they're expecting you and are on dress parade, as it were. Reminds me of the little girl who was told that the minister was coming to dinner and he was such a good man she must mind her manners very carefully. They were all so busy waiting on the minister that she was sort of neglected and got only some plain bread. She couldn't get her mother's eye and the butter was right in front of the minister. She wriggled a while and finally she says to him as polite as could be, 'Mr. Brown, won't you *please*, for Chirst's sake, pass the butter.' Now, *she* was on dress parade.

" 'But who has a kind word and a smile for everybody? Who looks after the neighbor's children when the mother is sick? Who sits up with her nights? Who makes custards and delicacies and takes them to the suffering?' says he.

" 'Who slips a dollar on the sly to some poor devil and tells him he'll boot him into Kingdom Come if he ever tells it? Humph! I've known many a good name ruined at a sewing bee by malicious gossip. Night before last I saw a bunch of fellows all set to throw a chap out of the tailor shop. They made it mighty plain what they thought of him. All because he had slurred a girl that they hardly knew anything about, being a newcomer. He either had to apologize or go out on his ear with no choice where or how he landed. What's your idea, Eph? Haven't heard from you, yet?'

“My idea is that the average man ain’t above makin’ out that he was a rip-snortin he-devil of a rascalion in his younger days and — don’t seem quite right to say it, though — that the average woman ain’t quite the saint she makes out to be. I reckon the good Lord made us about 50-50 so we wouldn’t embarrass each other too much.”

When my car was oiled and greased I had to go to a neighboring town to see a case of contagious disease. When I found what the trouble was, the mother flew into a rage, denouncing the family across the street, stating that her child had caught it from them, that she had known for over a week that they had the disease and that the local Board of Health should be prosecuted for failing to quarantine them. It is sad that so many people seek salvation by repenting of other people’s sins. I patiently explained that she too was liable, if, knowing that her neighbor had a contagious disease of that gravity for that length of time, she had not brought it to the attention of the board: that it was not only impossible but not the duty of the board to maintain police supervision over every house within their jurisdiction and that reports from the doctor in attendance (if any), from the head of the household, or from any who had knowledge of the presence of contagion, were the only means enabling the board to do effective work. Then I put a placard on *her* house, reported the matter to the local health officer despite her vigorous protests and she became still more furious.

I have been health officer in a consolidated district for over forty-eight years continuously. In the earlier years I had a lot of trouble with “grudge” complaints against neighbors for maintaining nuisances and unsanitary conditions on their premises. When I abated such a nuisance I was usually met with a storm of protest that it was a spite case. The name of the complainant was never divulged but, when the party of the second part made a good guess and stated that the party of the first part had an even worse nuisance on his premises,

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I immediately suggested a counter-complaint, which I likewise investigated. It did not take long for such complainants to realize that it was a poor rule that did not work both ways and they sought other methods of venting their spleen.

Quite recently a woman wrote me that her house was infested with bedbugs and demanded that, as health officer, I drive out there and get rid of them. Her complaint is on file but, so far, I have taken no direct action. Some years ago one member of our health board suggested that I was not earning my salary since I had not brought anything before the board for their decision. I reminded them that a silent running car was usually more efficient than a noisy one, and heard nothing further.

One of our best families had a lot of trouble with their well. They tried their best to locate the source of their trouble before calling me in. The head of the house said to his sister, "Well, Amy, I think the water should be all right now. I have had it pumped out and cleaned three times and put in chlorinated lime each time. I have put in new tiling and a new cement curb. Today I even sent our hired man, Charley Bastien, down with soap and a scrubbing brush and had him scrub each stone carefully, before letting the well fill with water."

"But did you scrub Charley Bastien first?" asked Amy. That was an essential point he had overlooked.

I had a lot of trouble with the Indians on the reservation, in enforcing sanitary measures and in controlling communicable diseases. The health laws came in conflict with their ancient treaty rights and legally we were practically without any real authority. Until they were thoroughly spoiled by too much paternalism, they were a likable people. Several times there were serious outbreaks of smallpox on the reservation and we had to resort to extra-legal measures, a rather risky procedure. We dug them out from their hiding places and vaccinated them almost like the Irishman played the violin, "not by tune or by note but by main strength." They

considered it sure death to wash up a maternity case. Peter Quart and his squaw, Mrs. Quart, would complain bitterly if we tried to enforce sanitary measures in their cabin filled with little Pints and Gills.

One Sunday morning I went up to see Mary Araquente who had a baby three weeks old. This time she was not feeling up to her customary standard. It was an early autumn day, the house was in a beautiful location with a magnificent view from the front. I had an old school-time friend with me. He had come up from Montreal to spend the week-end and I left him in my buggy under the shade of an apple tree reading the *Montreal Star*. I had occasion to get something out of one of my grips and as I left Mary's room I saw her little papoose leaning up against the wall just outside her door, swathed snugly on a papoose board bedded with moss. He was such a cute beady-eyed midget that I picked him up on his board and, carrying him under my arm, approached my friend. As he looked around I had a sudden inspiration. I handed the papoose to him. "Just a little souvenir for you to take back to Montreal." I said. The look of dismay and consternation on his face was, and still remains, one of the high spots of my ill-spent life. At length he realized, perhaps, that Mary might have something to say about this off-hand gift, whereat he grinned and called me a bad name.

Poor old Anna House had, in common with many of these Indian women, a voice as soft as that of a cooing dove. She was run over by a lumber wagon and sustained a fractured pelvis. Being very fleshy it was difficult to hold the bones in proper apposition but she was so patient and uncomplaining that I felt very sorry for her. One day I went up to see her and, sitting by her bed, I said, "Well, Anna, how are you getting along?"

She smiled at me gratefully and said, "Sometime I pain so hard I hope I die, quick. Then I think I take one of the little white pills you leave me (morphine) and pretty soon bimeby I think I like go Alexandria Bay and sell basket."

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The Indian is laconic but expressive. Old Running Deer had a daughter who was very ill. Two doctors met in consultation, one an elderly physician, the other a recent graduate. On the following day after much persuasion he reluctantly rendered judgment:

"Young doctor, he *little* de smartest doctor. Old doctor, he *little* de best *nurser*," which sized up the situation perfectly.

Dave Martin was just in. "This morning I come by Sugarbush Island. See two, t'ree bunch bluebill. I tell my boy no shootum. He say he no shootum. Mebby We'n'sday, mebby T'ursday big flock. I telephone I got sore foot. I want you come fix it. Bring minister too. You understand."

I understand. He is saving up those fat bluebills, fine-flavored when they first arrive from the North, for the Presbyterian minister and myself. If Dave telephones, we will have a glorious day on the river.

Many of these old-time Indians have afforded me keen delight. Caristocha's Island, (corrupted to Christy T.) was long in possession of an old full-blood chief of that name, a thick-set savage Mohawk. History has it that he killed another tribesman at St. Regis when eighty years of age. Under the tribal laws he was banished to the Island for twenty years but outlived his sentence. Nearly sixty years ago, my brother George and I were camping on Lac St. Francis and the old chief and his squaw were domiciled temporarily under a crude lean-to of black birches at one end of the Point near by. One night there came a long, heavy downpour and, in the morning, we wondered how old Caristocha, then reputed to be one-hundred and twelve, had fared. We found them drenched to the skin and huddled around their camp fire preparing breakfast. They had about two quarts of hard, green, russet wild apples, marble-sized, which they were boiling in an iron pot suspended over the fire, nothing else.

We went back to our cabin, returning with a loaf of bread, some potatoes, salt pork, four eels and a supply of tobacco.

How their black, beady eyes glistened at the sight of some real food! I have a vivid remembrance of their cutting green sticks and thrusting the sharpened ends through the eyes of the eels. Without stopping to dress them they simply held them over the coals until partly broiled, then they peeled back the skin and ate the cooked portion in two-fisted fashion as one might eat corn off the cob. I can still see the eel oil running down the wrinkled neck of the old chief, where his shirt was open at the front. From then on they were quite friendly with us.

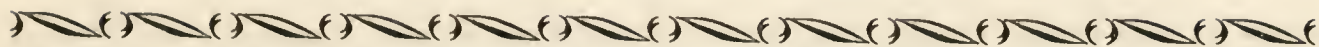
In addition to the iron pot, sheath knives, a few battered tin dishes, they had an old black oilcloth satchel containing some official documents from which we learned that he had fought with the British forces in 1812, being in command of a band of Indian scouts. At night we often went to his camp and listened to his tales of "The Big War" and his description of how the Indians tortured and mutilated their captives. "Cut off um nose and ears and t'ings and t'row um in fire," whereat his fat old squaw would shake with laughter.

Two Scotch boys, William and John Fraser, part owners of the Point, joined us one night and quietly began poking fun at the old man. His native dignity was ruffled but he did not show it save by a peculiar gleam in his eye. They teased him to tell more stories but he shook his head. Finally he relented. Lighting again his stubby clay pipe he said in his laconic fashion, with many brief pauses:

"I tell just one (puffing from his pipe). In the big war, by Chateaugay River (puff), t'ree Yankee chase t'ousand, w'at you call regiment, Scotchmen. T'rough heap big swamp, t'rough woods (puff). Chase um, chase um, chase um, by Caughnawaga, chase um two days (puff). Next day, me (puff, puff, puff), I kill de t'ree Yankee."

If I interpreted his subsequent grim silence correctly, the moral was:

"Scotchmen no good. Yankee [George and I] heap good. Injun damn good."

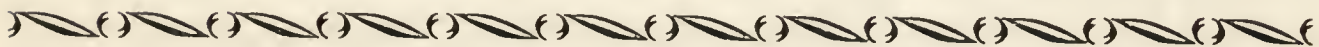


X

PATIENTS AND IMPATIENTS

“The battered gate, the clothesline whence there fly
The short and simple flannels of the poor.”

—*Elegy of a City Back Yard*



OUR French-Canadian element was large and rapidly growing larger, this long before Oliva Dionne, much less his quints, was even born. In Antoine Beaudoin's house I was writing a prescription for one of his progeny. “What is this little girl's name?” I asked.

“July Ann,” said Antoine.

A red-headed one in the corner said, “I'm July Ann.”

“Well, Mary Ann.”

“That's Mary Ann in the rocking-chair.”

“Sary Ann, then.”

Mrs. Beaudoin spoke up. “Antoine, you should feel for shame not to know the name of your own chilluns!”

“Well, Matilda Ann, dang it all, I got so many I forget sometimes,” which was in a way excusable since he had twenty-three. When we used to play quoits we always counted the score out loud, “One an', two an', three an',” for some cryptic reason. Possibly Antoine may have known.

Quite recently I attended a woman in her twentieth confinement. At a subsequent case a woman was asking about this. “All by the one man?” she inquired.

“Do you think that a nice question to ask any lady?” I countered.

We had a wide territory to cover. Midwifery constituted a large share of our practice, nearly every day being Labor Day. Nights, too. When I hear the old phrase about having your labor for your pains, I feel it must have originated in reference

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to a still-birth. In one of my early years of practice I had so many mal-presentations that I scrubbed my arms to the shoulders at the start, expecting to do a podalic or a bipolar version and I naturally grew quite expert along these lines.

I remember how I was called about two o'clock one rainy night to see a woman who was sick. My horses were very tired so I donned a rain-coat and sou'wester and went a mile and a quarter on foot. It turned out to be a confinement case and the grandmother scolded me because I was slow — she had buried five and one-half husbands. One she had lived with for three years without getting married. I allowed her 50 per cent on that one, otherwise it would have been six, all of them no-accounts in every sense of the term.

"Why didn't you send some word by the little girl who brought the message so I would have some idea what the case was?" I asked.

"I t'ought you'd know."

"How was I to know. I haven't seen your daughter since her previous confinement a year ago."

"Well you needn't get mad about it," she grumbled.

"I'm not mad. I've doctored you, all your husbands, all children and grandchildren, all your sisters, your cousins and your aunts for many years without getting a sou marqué for it. If the whole lot were put in a big vat and boiled down to a black, sticky mess, it wouldn't be worth a decent man's losing his temper over."

Her subsequent silence was exceedingly profane.

One of the relatives wore me out after a period of years and one day I refused to go to his place to dress a bruised thumb. One of my friends tells with great glee that Ozeas said, "I told that this and that of a doctor just what kind of a something or other he was."

Knowing my tendency to plain speech, my friend asked him, "What did the doctor say when you told him all this?"

"Oh, he didn't hear me. He was up-stairs in his office," said Ozeas.

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At this time it was considered sure death to give a woman cold water for a week or so after delivery and the same was equally "true" of measles. Argument was of no avail against this superstition. I ended it, however, by giving every such case a full glass of cold water just before leaving the house. In a few years they saw the light. Other notions were more persistent. Within the past month I arrived at a house to find that the baby had been born a few minutes after the messenger had been sent for me. Meanwhile they had secured the placenta safely by tying the umbilical cord to the mother's knee. Otherwise it might have strayed away from them before I could remove it. Some of these fool ideas will be as hard to kill as burdocks, will persist despite all reason for a thousand years. But, perhaps I am too conservative in my estimate, as usual.

Very early in my career I had a confinement case on the Indian Reservation. She had been in labor two days. There was complete uterine inertia. After delivery with forceps and removal of the placenta, I could get no contractions whatever. I gave a hypodermic of ergotine, pituitrin being, of course, unknown. I called for hot water which I had in readiness. It had been used for other purposes. I asked for vinegar, for turpentine, for clean muslin. None was available. In desperation I asked for ice. The Indian took a tomahawk and cut some from a pond near by. I slipped this up to the fundus, the uterus contracted promptly and the alarming hemorrhage ceased. She got well without untoward incident and without a hay crop. I had noticed a few blades of grass in the ice but some good ice would have been of no avail after she had gone to the Happy Hunting Grounds from the active hemorrhage. I had begged for everything I could think of and beggars shouldn't be choosers, particularly when no choice is offered.

One idea that was common among the old women who did the nursing of the sick in those days was that it was unsafe to treat a baby with scald-head, teething eczema, and

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the like without giving a "blood purifier" at the same time, citing numerous instances where serious illness or death had followed such procedure. A wide experience in the treatment of these conditions leads me to believe that there may have been a little truth at the bottom of this well. Some of these old ladies were close observers and clever enough in their way, if you ask me, or if you don't, for that matter.

I had to drive some twelve miles to see an Indian who had gotten in a little disagreement with another Indian's squaw. She had sliced his head open with an axe and the skull was badly splintered. I sent messengers to various near-by towns for other doctors but none were available. I explained to him that I could not give him ether and do the operation too; that unless he wanted to have his friends walking around him in single file saying, "How natural he looks," he would just have to stand the pain. He agreed with Indian stoicism. I fixed him up all right but when I drove up the next day I was anxious to see how he was. Sitting on the front step was a youngish man whom I took to be a newspaper reporter. He stopped me and said, "Is this man going to die?"

"I can tell you better when I look at him."

"Was his skull fractured?"

"Yes."

"Did you take some of the bone out?"

"Yes."

"Where is it?"

"In a good safe place."

"You are not very communicative. I can make you talk," he said, getting red in the face.

"You're not man enough, you damned whipper-snapper."

"I want you to understand that I am the District Attorney of Franklin County," said he.

"You may be the Great Mogul of Hell for all I know but, if you don't get out of my way and let me see my patient I'll knock your block off."

By the time I had seen my patient and come out, we had

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both cooled off a bit. I found that he was the District Attorney (afterward Judge) of Franklin County. He, in turn, realized that I had no business talking too freely with a stranger about what might easily be a murder case.

One of my earliest cases was a fracture of the neck of the humerus. The patient was a man of ability and prominence but as gruff as a grizzly, with a humorous twist, however. His first words to me were, "Dammit, I was sober as a judge when I fell off the piazza. If I'd been drunk it never would have happened." I went down to see him one day and met him coming up the walk. Brandishing his stout cane at me he shouted, "Go back. Go back, damn you." As I drew nearer he growled, "Dammit, go back and call it half price." Every time he would meet me after that he would say, "Damn lucky thing for you, young fellow, that my rheumatism settled in the leg I busted thirty years ago instead of the shoulder you set."

A corpulent old lady who lived at his house had a long illness. I noticed a big iron ladle hanging on the bedpost. I noticed that the wood was worn where the spoon had rubbed and this aroused my curiosity. I asked her why she kept it there. "That is a fat lady's back-scratcher," she told me.

We had a few scattering Christian Scientists. One of them had cancer of the gall ducts. Her brother met me one day and said, "You told our folks that she would live about three weeks. They tried Christian Science and shortened it up a week on you." Her sister over-ate one Thanksgiving day and was in such pain that she had to send for me. I gave her a hypodermic of that quick-acting emetic, apomorphia, saying, "Here is a good chance to test the superiority of mind over matter. Prove it if you can." She gave it up, all of it, within three minutes, in a washbowl.

We had a telegraph system, limited. One could send ten words but I stacked hundreds of telegrams on a spike file and about 99 per cent read simply, "Come at once." No other

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information. With a pair of saddle-bags our equipment was limited and this developed a lot of Davy Crocketts among our pioneer doctors. Ammunition being limited, with no magazine on our rifles, we had to make every shot count. It was sometimes maddening to get two "come at once" telegrams, toss up a penny to see which to attend first and find that you had spent an entire forenoon visiting a patient in one locality twenty miles away with chronic rheumatism, then return home and learn that the other patient, living fifteen miles away in the opposite direction, had had his arm torn off at the shoulder in a threshing machine.

Later, of course, we had telephones which were not unmixed blessings. One man called me up at 3 A. M. "You don't know me. I'm Mr. Brown from Utica. I want to find out how to get to William Nokes' house and I found your name in the telephone book. I hated to wake anyone else up but I saw you are a doctor and you would not mind because you are used to it." Another said it was urgently necessary for him to get something at the drugstore. He was waiting when I unlocked the store door. He wanted a rubber nipple. When I gave it to him he threw a nickel on the counter and walked away without bidding me good night. This at that still, midnight hour when churchyards yawn. They could have yawned for him without making me grieve poignantly.



XI

THE YOUNG DOCTOR

“Students from the middle third of our classes are the most successful in life. They are not brilliant enough to become professors or dumb enough to have to work.”

—*Sir Henry Thornton*



THIS chapter is written at the urgent request of a number of young physicians. They want advice. Now there are three kinds of advice, good, bad and indifferent; therefore, on the face of it there appears to be but one chance out of three of advice being good. Despite this handicap, I must make the attempt, having one consolation. If I fail I will be with the two-thirds majority.

Being an old-timer, I date back to the age when that glorious constellation in our Northern heavens, known as the Big Dipper, was about the size and shape of a silverplated baby spoon. The advice I lay on the table is therefore apt to be plain and informal. Moreover, it must be borne in mind that even in these days of advanced knowledge, nothing is known positively and completely and that I sometimes disagree with my own opinions.

These young doctors, under my wing from time to time, ask for advice with special reference to the young medico who is about to settle in a small town or who is endeavoring to decide between an urban or a rural location. Each has its own appeal, each its special trials and tribulations. Our mentalities differ and we are governed largely by our predilections. Fortunately the troubles which afflict the country doctor are seldom the same as those which distress his city brother.

The young doctor whose chief desire in life is to become famous will do well to select a city. He will have the advan-

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tage of contact with men of ability and exceptional skill. Hospitals, libraries, laboratories and all the modern aids and conveniences are at his disposal. Expenses will be larger but he will get bigger fees. With institutional beds in convenient rows, he can see more patients within a given time. There are numberless advantages which we need not enumerate.

The struggle to obtain a foothold and a livelihood will be greater in the city, the hours longer and more arduous in the country. It is really too bad that the only reasonably sure way to success is by work, but it is nevertheless true.

The young medico starting in the country needs the missionary spirit. The work will try his metal and his mettle. He *may* become famous but the chances are against it. He can become nearly an absolute monarch in his own domain but that domain will be relatively small. As Uncle Eph says, it is all a choice between being a big toad in a little puddle or a little toad in a big puddle. He will have little serious competition. He will be compelled, however, to stand on his own feet. He will often be unable to shift responsibility to the hospital staff or to the specialist no matter how desirable this may be. This may make or break him when he must tread the winepress of professional anxiety alone. He will meet with many difficult situations and must learn to cope with them.

Robert W. Chambers says, "There are two ways of facing a rotten situation. Get under the bedclothes and try to forget it, or get up, put your pants on and go out and face it."

We need good men in the country. J. G. Holland put it:

"God give us men. . . .

Men who can stand before a demagogue
And damn his treacherous flatteries without blinking,
Tall men, sun crowned, who live above the fog
In public duty and in private thinking."

His motto should be "*Sursum Cauda*." A free translation might be, "Keep your tail up." Idiomatic phrase signifying

grit or courage. He will have plenty of hard work but it is to be remembered that hard worry is what kills. All this will be discouraging to some, to others but an added incentive. It is better so. Hard jobs require hard men. Reverse it if you will. "Better a mud-stained car running under its own power than a shiny one being towed in."

The country doctor is not able to systematize his work or limit his office hours so definitely as his city brother. He will be, in a greater or less measure, isolated and, due to this, he must be ever watchful to keep an open mind, to keep in touch with medical progress and still exercise his own judgment. His population shifts but little from year to year. He can follow up his cases far better than the city doctor — follow them from generation to generation. He can acquire breadth of view if he will. He can live his own life and not become a mere carbon copy. He will not feel obliged to maintain an impressive and oppressive dignity.

If he settles up in the North Country, where the mean temperature is apt to be mean all winter long, he will have many a long drive in what is known as a Chateaugay thaw. "Forty below and a whale of a blow." Every ointment has its fly. He will lead a more normal life, have a real home instead of a rented flat, have a better place to bring up a family. City streets crowded with humanity, carbarets that are forever cabaretting, do not appeal to all. A million or so of shoving, elbowing, hurrying and scurrying mortals seeking refuge from themselves, the rush of the subway, the rattle of the steam riveter, the uproar of the elevated. He must choose between the many advantages of city life and its disadvantages. Muggy atmosphere, steaming sewage, the sense of filth. City dirt is not earth. It is approximately 100 per cent plain filth, scrapings and refuse from unclean things and unclean people — oft-times, people who need five or six baths in rapid succession to make them even superficially clean. Earth is only *called* dirt in the country. It is compara-

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tively clean loam, clay, marl, sand. People have vile diseases in the country, too, but we usually know who they are.

In the country he can have things that are without price, priceless. The soft sublimity of the spring woods: "What sunshine treasured up! What wine of joy that blends a hundred flavors in a single cup!" In the June sunshine he can find rare orchids and *Linnaea*. He can wield a casting rod in the near-by stream for black-bass or whip the brook with a trout fly. He can roam the wilderness in the lovely October haze or find delight in the silences of the winter woods. If he will, he can give joyful ear to his pair of beagles making mad music in the wake of the big snowshoe hare. Uncle Eph says, "The woods is the place for a fellow when his soul gits itchy," and, "Even a skunk likes the woods."

As for making a living in the country, the young doctor need have little fear. There is always plenty of work to do if he has the ability and is willing to do it. Coleman Cox says, "I am a great believer in luck. The harder I work the more luck I seem to have."

Uncle Eph says: "Some folks don't seem to have much luck. There was Joe Sykes. His cat got her head in the milk pitcher, so he cut the cat's head off to save the pitcher. Then he had to break the durn pitcher to get the cat's head out. He didn't even save the cream. He told Si Perkins he had blamed tough luck. Some of the neighbors, though, called it something else again."

I have been repeatedly asked regarding the income of the average country doctor. I know of nothing more deceptive than averages. We all know of the man who got drowned in the pond, the average depth of which was two feet nine inches. Anyone with sufficient gray matter to solve the riddle of why white sheep eat more than black, should understand this one. I have seen many statistics showing the earnings of the average physician. They vary within exceedingly wide limits. My own observations lead me to believe that the average doctor does not know definitely just how much he

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earns — and collects. This naturally tends to throw the statistician off center. I know of many country doctors who merely make a comfortably bare living. I know others who have grown wealthy. One of our doctors saw me jotting down entries in a little red diary which I always carry. "I have no doubt if I did that I would save several hundred dollars a year," he said.

"Several thousand would be nearer it," I replied, and knowing the amount of work he was doing, his scale of fees and his business methods (or lack of method), I was quite sure of this.

The matter of business prosperity lies in maintaining a proper relationship between income and expenditure, a thing that is measurably under our own control. The bulldog wins chiefly because he hangs on. Hangs on to what he gets. On the other hand, a good library, plenty of instruments and proper equipment is not a part of the expense of living. Even for income tax purposes this is recognized. It is a capital investment yielding a good return. It is a capital investment in every way.

The country doctor should learn to prescribe inexpensive remedies when they will do equally well, rather than the highly advertised proprietaries. Country people are not over-critical in this respect. If the young doctor is getting five or ten dollars for an office call he can disregard this advice but, if this be so, he is doubtless no longer living in the country. The man who, after taking thought, cannot decide whether he will choose a country or a city practice will not amount to a great deal anywhere. He will be like the old darky who rode all afternoon in the merry-go-round. His wife said to him, "Eben, you done spen' all youah money an' you done hab youah ride, but *wheah you-all been?*"

Rightly or wrongly he must come to some decision, else he will be in the quandary of the little girl who asked, "Mamma, if I grow up and get married, will I have a husband like Papa?"

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“Yes, dear.”

“And if I don’t get married, will I be an old maid like Aunt Julia?”

“Yes, darling.”

“Gee! Ain’t I in a whale of a fix!”

The young physician who finds it difficult to decide may be wise if he adopts a middle course and selects a large town or a small city. There was Colonel Whitcomb of South Carolina. While he was hunting quail one day, he met up with a party of local sportsmen, and one of them said, “Good morning, Colonel. What luck are you having?”

“Just tolerable, thank you kindly, gentlemen. First part of the day (hic) the birds got up in a most peculiar mannah, (hic) three at a time. I kept missing them and missing them with either (hic) barrel. Couldn’t account for it nohow. My laigs got rather tired so I whistled in my dawg, sat down on a log, took a little drink, smoked a seegar, pondahed a little and decided (hic) that if they flushed that way again, I would shoot at the middle one, after which I had much better success, thank you kindly, gentlemen.”

This not only indicates that a compromise is occasionally advisable but that impaired visual co-ordination does not necessarily entail defective judgment.

XII

FEES

"The first and worst of all frauds is to cheat oneself."

BAILEY

FEES are not always to be computed in dollars nor are our annual incomes to be reckoned by a comparatively simple adding up of the debit and credit columns and striking a balance. Some fees are perennial, giving us pleasure year after year, paying us, over and over again, generous dividends on small investments. The doctor who measures his income on the dollar basis never gets to first base in life's game. He isn't worth a tinker's dam—which, by the way, is not a cuss-word at all. If such were the case, if we did not learn to fuse rather than to confuse the two types of fees, we would be committing that worst of all frauds, cheating ourselves. To illustrate . . . while attending a patient with a fractured hip, her lovely little granddaughter brought me her dolly which had sustained a fractured skull. I took it home and, after doing a little plastic surgery, returned it to her on my next visit. A few days later the little one climbed in my lap, kissed me shyly and put a scarfpin in my tie. "'At's for fixing my dolly.'" The pin was a little the worse for wear, having been bought at the ten-cent counter some years previous, I think, but this had no bearing on the matter.

About forty years ago a lady who had been ill for many months but was fully recovered, came to my house with a big basket of golden russet apples, the pick of her orchard. Giving a quick glance through my office door she said to the maid, "Tell the doctor that these apples are to pay for the medicine he gave me. I will return all his visits." A few days later I received a check for my bill. I felt doubly paid.

I recall one young woman who lived up in the "sand

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plains," a very poor section. She had been brought up in squalid surroundings, had no education but was instinctively a real lady, why, I do not know. I attended her in numerous confinements. Her husband spent all he earned in dope and whiskey. She always paid me my fee, mostly in quarters and dimes earned by doing washings for the neighbors for twenty-five cents and picking berries at ten cents a quart for wild strawberries and raspberries. For blueberries she got eight cents. My fee in her case for an eight-mile drive and delivery was always five dollars.

She had a chronic dacro-cystitis of the lachrymal sac following a severe and obstinate attack of trachoma which I had cured. I excised the lachrymal sac, charged her five dollars and the result was entirely satisfactory to all concerned. Some years later she got a job as scrub-woman in a hospital in an adjoining county. One of the specialists there, noting the scar, made some inquiries as to who had operated on her eye and what she had paid for the operation, then exploded: "Good Lord, woman, don't you know that operation was worth at least a hundred dollars?"

She came to my office sobbing and wanted to pay me more money. I said, "That operation was all right, wasn't it?"

"Yes, I never had any more trouble."

"You paid me all I asked, didn't you?"

"Yes, but now I know you didn't ask enough."

"If I'm satisfied and you're satisfied, that's all that need be said of the matter."

I had saved her the crowning virtue she possessed, her own self-respect. *That* was my real fee.

Not all our patients are so grateful. Frequently we must look for our own reward as the Irishman did. After meeting with head winds and boisterous seas in the old days of the emigrant sailing ships, he said on landing, "Faith, an' I've got six weeks rebate in Purgatory comin' to me."

There are many rewards which never reach the front page. I often meet a lovely and wholly estimable young lady with

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a warm glow in my old heart. People who see us in animated conversation and perhaps the young lady herself, probably think her allure kindles delight in me, and it does, but the real reason is that I refused a fat bribe and an insistent demand, finally persuading her parents to let nature take her appointed course instead of terminating her life during the second foetal month. She will never know the true reason for my manifest interest in her.

In my daily rounds I run across worthy young men and women, healthy and useful citizens who would not be here if I had not insisted, despite the reluctance or downright opposition of their parents, on operations for spina bifida or similar congenital abnormalities of the new-born, this in the days when operations of this character were denounced and I was risking my reputation in doing them. Such "fees" afford enormous satisfaction, although not acceptable at any bank of deposit.

One bitter January Sunday morning, an Indian with a humpbacked white horse pulled up at my hitching post and came in. "My woman, she very sick. Try to have baby. Five days she most die. Injun doctors try hard. No good. I come for you."

They lived ten miles away on the Yellow Island below Cornwall, Ont., at the foot of the Long Sault rapids of the St. Lawrence. The ice between the main land and the island is always treacherous on account of the swift water. I crossed without mishap, my horse instinctively avoiding the dangerous spots, and arrived at the Indian's cabin. The squaw was in a desperate condition. Had she been a white woman the funeral would have been over with long before my arrival. She was apparently unconscious, with a pulse which I could not count with any certainty and a temperature of 105.

I could get no evidence of foetal heart sounds or movements. When the child was delivered I looked at it, decided that it had been dead for about two days and hurriedly laid it aside on the foot of the bed, knowing that the woman could

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not survive unless given immediate attention. I worked over her for some twenty minutes and she began to rally. At this time my attention was attracted by a low wail from the foot of the bed and to my utter astonishment, I saw the papoose kicking vigorously with his beady eyes wide open.

In the course of an hour or so they were both safe and I prepared to leave. The Indian father asked me what my bill was. I looked around me, sized up the situation, told him I would have to charge him five dollars. He paid me and went out to hitch my horse. As I was buttoning up my fur coat I saw the woman looking at me intently. Up to this time she had not spoken, though conscious at times. "I'm going now. Is there anything you want to ask me before I leave?" I said.

"No. Only *thank* you and *much obliged*." I think *that* was one of the best fees I ever received.

On my way back I was less hurried. I watched with much interest a bunch of golden-eyed or whistler ducks feeding in a near-by airhole. There was a keen breeze sweeping across the frozen expanse of Lac St. Francis. Big and Little Cow Islands, Corn and Sugarbush on the Quebec side, Canal, Stanley, Hawk and Hamilton Islands on the Ontario side, Round, Plum, Snake, and Caristocha's below and, in the distance, Butternut and Kit-kit Islands thrust up through the glittering field of snow-covered ice which in the north-east met the horizon.

Once on the mainland, my pony struck into his swift, easy gait for the sheer love of it, swinging a watchful eye at me from time to time.

A big white hare left his form in a bunch of ferns and with long, springy leaps crossed my path into a thicket and sat upright beneath the sprays of scarlet winterberry, our Northern holly, thinking himself safely hidden against the white background of snow.

I crossed the marsh noting the tracks of a red fox, a mink, and from time to time the footprints of a musk-rat with the clear groove of his trailing tail; the tiny imprints of number-

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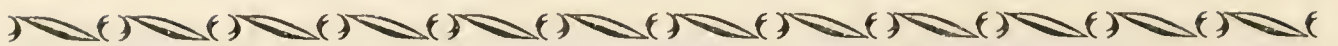
less white buntings, these "snow birds" driven in by the deep snows of Northern Ontario to feed on the projecting tops of our golden-rod, here within easy reach; the swift swirl of a hundred of these birds, from a field covered with rag-weed, to another weedfield.

I passed a flock of evening grosbeaks busily nipping and shelling the seeds in some ash-leaved or Manitoba maples. I smiled as I watched them, for our bird scientists had been puzzled over the shifting of these Far Western birds to the Eastern States, and decided that it was time for me to suggest that the ash-leaved maples hold their seeds winter-long, that they were being set out in ever increasing numbers toward our Atlantic seaboard, that their seeds constituted the main item on the bill of fare of these grosbeaks, and that the "mystery" of their change of habitat was no more a mystery in reality than my little spaniel, Dom Pedro, when he followed his dinner plate from the kitchen to the woodshed.

Then a cedar thicket and a lordly cock grouse strutting alongside with spreading tail-feathers and horizontal ruff—exhibitionism at its best—while his mate stood erect as a statuette among the fox-grapes of a vine-covered tree, watchful, motionless, ready for instant flight if I so much as turned my head in her direction.

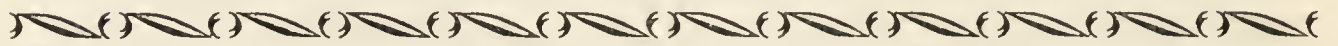
Under a rosebush beneath a cottage window a brassy-eyed white owl swooped down silently and seized a big Plymouth Rock sheltered beneath the bush. He rose heavily with the bird in his talons and, touching up my horse, I struck at him with my whip as he passed overhead. Dropping the hen which scuttled back hurriedly to home and safety, the angel-winged but black-hearted owl lit ahead of me on a haystack and with baleful eyes and snapping beak, hissed wickedly at me as I passed him.

And then—home to a warm dinner and a steaming cup of Java. It had been a lovely drive along the St. Lawrence, a fine, brilliant winter day, the fee had been wholly satisfactory and all was well with the world.



XIII

BEGINNING PRACTICE



✓ THE young doctor, regardless of where he locates, need not expect to please everyone. Some patients remind me of the lowly but succulent bullhead, which is not outwardly attractive, has little imagination, and will accept nothing but the cold worm of fact or something equally nutritious. A pickerel on the other hand, will dart across a stream to seize a glittering metal spinner armed with three hooks partially concealed by peacock feathers, a bait which contains no nourishment whatever, naught but a masked peril. When you disgustedly cast him overboard he repeats the act at the earliest opportunity. So, too, with people. Any old hook, provided it be attractively feathered, will be readily swallowed by a certain class of patients. Some will accept nothing but a wholly marvelous and an unholy and scintillating lie. What they want is a miracle. This trait is not confined to the ignorant, to the uneducated. Many of our finest and most intellectual people are thus the natural prey of the quack and the imposter, prophets with an eye to profits, seers clad in seersucker. The patients furnish the sucker element. No one man can hope to catch bullheads and pickerel successfully on the same line.

Contentment is a virtue to be cultivated, else we find ourselves handicapped like the Scot who had to quit smoking, giving as his reason, "It is nae comfort whateffer. If you smoke your ain tobacco it costs you o'er muckle, and if you smoke another body's tobacco you fill your pipe so fu' it won't draw."

Praise is pleasant but must not be taken too seriously. Adverse criticism and disparaging stories about you should be

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disregarded. You cannot chase up lies successfully. They will soon exhaust themselves when they have run far enough. Remember that no one goes out of his way to kick a dead dog. The worst that can happen to you is to have people quit talking about you. For every individual who condemns you another will rise to your defense. If a doctor does what he believes to be right and treats everyone as well as he knows how, he should be able to maintain his own self-respect and in this way please himself.

He should make no effort to induce patients to come to him, nor should he knowingly permit relatives and personal friends to do this. If patients come to him voluntarily and he does his best by them, the outcome is in the hands of the Omnipotent. If he, directly or indirectly, persuades a patient to doctor with him and the result is unsatisfactory or disastrous, how can he know but that some other physician more skilled in that disease might have cured that patient? It is not given to any of us to know it all. By using influence to obtain patients, he assumes a responsibility which no conscientious physician is willing to bear. None but a medical prostitute will solicit patients. Hence the ban on medical advertising.

Some patients should be handled with gloves. They are naturally thin-skinned, sensitive to a fault. Some others need special gloves—boxing gloves. Most patients, if seriously sick, are depressed. I am not referring solely to mere physical depression. They want cheering up, bracing of their moral spines, toning up of their spiritual fibre. This is one of our chief remedial agents. All of them, or nearly all, crave sympathy. It is often quite as injurious as a narcotic. The young doctor with college debts hanging over him, and with but two or three patients, can perhaps afford to be sympathetic. It is a life-saver to him. Three such pay patients should keep lupoid visitors from his door and give him constant occupation until such time as he acquires a real practice.

He should not put too low a valuation on his services but, in the case of those well able to pay, charge reasonably full

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fees. If his fees are too low he cannot expect the public to put on a higher valuation. Their opinion of his services is apt to be equally low. He should bear in mind that the laborer is worthy of his hire — this provided he does not always spell it h-i-g-h-e-r.

He should remember that a patient, or his friends, has the right to ask for a consultation or a change of physicians; this, provided that it be done openly and with due notice. Were I a patient, and my doctor refused a consultation, I would tell him that his services were no longer required. He should afford Roman Catholic patients every opportunity for the rites of private baptism and extreme unction. It is their rite and their right. He should guard his reputation, control his desires and inclinations, be captain of his soul, be a straight shooter and live up to the code of medical ethics, which is simply a set of rules for gentlemanly conduct, conducive to one's self-respect.

✓ In consultations, "Where three men guess and sometimes one man knows," as the Autocrat puts it, he should respect the other man's opinion even though he is compelled to disagree. He should refrain from criticism of his confrères. Such comments are not only unworthy and ungentlemanly but, like a catling, cut on either side. He should learn to be a good collector. Someone has said that a salaried man gets so much per week but that a doctor gets so much per-haps.

He should reflect that, while honesty is the best policy, as well as possessing other merits, it may be poor policy to call a welterweight a liar just because he honestly believes him to be one. On the one hand, an unwillingness to play second or third fiddle indicates a hereditary taint. On the other, to be subservient, to abandon his principles and smother his conscience, is unworthy of a self-respecting worm.

He should be close-mouthed. He may follow, if he will, the example of one doctor who, when asked by a lady with overweening curiosity a question which came under the head of

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private and privileged communication, said to her, "Can you keep a secret?"

"I certainly can and will."

"So can I," replied the doctor.

He should beware of shady ladies, even of over-grateful female patients; likewise of that festered shrimp who insists that his affinity, his one and only soul-mate, be relieved of her trouble. If, unfortunately, the doctor yields to their persuasions, the aforesaid affinity will assuredly pass the good news to her other lady friends and intimates. The echo will not quickly subside. An evil reputation can be acquired almost overnight in this way and it is not only fragrant but lasting. He may also acquire free lodging at State expense where no dogs will bite him. He is likely to land eventually in that place in which the Universalists profess total unbelief.

He should consider that too much celebrating has kept many a doctor from becoming celebrated; that giving out needless information is unwise. Regard for his patients and for his own career should reinforce this. Careful steering is more effective than persistent honking. If he follows the one course, his patients will swear by him; if he follows the other course, they will swear at him.

As a general rule, the doctor will find that he will get just the same fee for twins that he gets for the customary single birth, thus going the famous 1 cent sale one better. A notable exception is Dr. Dafoe, but even in his case he doubtless collected only his usual fee, the government salary and other emoluments being sort of supplementary, as it were.

The young doctor will learn that when he holds the baby and it cries, this is due entirely to the awkward and masculine way in which he holds the dear child. When the mother, or even the maiden aunt, cuddles the infant and it cries, the sweet little precious darling has a pain in its dear little tummy-tummy.

"Darling" is an appropriate term to employ regarding babies. It is a fine word but should be used sparingly and

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with discretion in the case of, well, let us say, approximately fifty per cent of our adult population.

Many young men have asked me if I would advise them to study medicine. My invariable answer is in the negative.

"Are you sorry you studied medicine?"

"No."

"Don't you think I have enough brains?"

"That is wholly aside from the point at issue. The very fact that you asked my advice is justification for my answer. Don't do it. On the other hand, if you want to study and practise medicine enough to make a good doctor, to put up with the long hours, hard work, anxiety and hardship which it entails, if you are willing to hustle around like Mephistopheles with a tin can on his tail, if you want to do it because no other vocation will satisfy you, you would never have asked me this question or, if for any reason you did, you would disregard my advice, so no harm would be done. In that case, go to it, and may God go with you."

Even without all these valuable suggestions, he will gradually acquire wisdom in gobs and hunks. You just bet he will and, above all, he should heed the adage that particularly applies to country towns and villages, if not to civic centers, "Any fool can get a practice but it takes a good man to keep one."

He can learn to be courteous even when imposed on. He can learn this even from a bartender.

One John Flaherty placed a bottle of rye in front of a penurious and grasping customer who filled the glass to the brim and shoved over the customary price of a drink, a thin dime. John returned a nickel to the customer.

"I thought the price was ten cents," said the man. With a cheerful grin John said, "Oh, no. Not wholesale."

I was driving up Deer River way one frosty winter night. I saw a team coming. From the way the man was swearing at his horses I knew he had been drinking, so I gave him a wide

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berth and the whole road. As he was passing he slackened his speed, "Who in blazes are you?" he blurted.

"Doctor Macartney."

"Go to Hell," he shouted.

"Same to you, sir. Thank you kindly," I replied and he drove on with a great roar of laughter.

From a still different slant is the story of an old Scotchman who so often became drunk that his auld wife thought she would throw a scare into him. Late one night she dressed up in a black robe and, with a pair of horns, and a clanking chain in her hands, she barred the gateway as he lurched up to it. "And who micht you be?" he asked.

"I am the Devil, Auld Rookie," she answered in as deep a voice as she could muster.

Clapping the spectre heartily on the shoulder he shouted, "Come into the hoose wi' me. I marrit your sister."

XIV

GENERAL PRACTICE

A NUMBER of years ago, Abraham Jacobi wrote an article entitled "*Non Nocere*," which was a jewel. There was more meat for digestion in that brief essay than in many a pretentious volume. In that article he refers to "the absolute and indestructible dependence upon each other of each organ and the organism." So long as this remains indisputable, just so long will there be a practically unlimited field of general practice occupied by those of us to whom its wide scope has a distinct appeal. Nature constituted many of us Jack-of-All-Trades and, if you will, master of none. But in medicine there is but one Master, the Engineer in Chief to whom we must all bow. Many of us were never built to be anything but general practitioners. The work has a never-failing attraction for us. We grow stale, lose our interest, if confined to the narrow limits of one line of endeavor. We never know what we may be called upon to do next; what emergency may arise to tax all our resourcefulness. "Age cannot wither her, nor custom stale her infinite variety." Then again, some of us like to stand on our own feet. We prefer plenty of elbow-room. We are independent enough to prefer to scratch our own fleas.

There will always be a field for the all-round handy repair man as distinguished from the expert on part 726 of Model 384, if you get what I mean; for the hard-headed, resourceful and well-balanced general man-of-all-work as well as for the specialist. Each has and will continue to have his appropriate and proper sphere, following as best he can the great blue-prints of his Chief Engineer. I sometimes wonder if the public, the lay press, and the "Arrowsmith" type of writer

who would rather appear clever than be correct, do us full justice. It would, possibly, be too much to expect.

If an automobile fails to function properly, develops some acute disturbance due to a short circuit, has a clogged feed-line, a warped valve, a timer out of adjustment, a piston slap, a carbon knock or meets with a smash and is wrecked, it should always be possible to put it once more in working order. Given time, new parts, skilled mechanics with proper equipment, and experienced electrical experts, there should be no serious difficulty, provided expense is no object. It is a man-made machine and it should be humanly possible to adjust, repair or duplicate any part thereof, in fact, all parts, if need should arise.

By contrast, physicians and surgeons have one of the biggest jobs, if not the biggest, known. We endeavor to keep in good working order a mechanism made by Divine hands — this despite our poor human limitations. Centuries hence, strive as we may, the best of us can hope to attain no more than the status of the tinker and the cobbler, the “one-gallus carpenter” — to use the Southern colloquialism — the only wonder being that we do so well with a task that is more than man-size. In view of this, the public might exercise greater charity in criticizing our manifest shortcomings. We might even take the lesson to ourselves, when we differ, and be more lenient with each other. Likewise it is our duty to teach our patients to take care of their bodies and, in so doing, to exercise as good judgment as with their Packards and Panhards. To teach them this is not merely a moral responsibility, but we should consider it our high privilege, and here the general practitioner is the keystone of our professional arch.

Dr. George E. Vincent, of the Rockefeller Foundation, has said, “Seventy-five per cent of our population are still being treated by the general practitioner” (others put it eighty per cent). . . . “There still remains a need for the general practitioner which no specialist or hospital can satis-

fy. . . . The well-trained, properly equipped general practitioner of ability, character, personality, is a fundamentally valuable person. He is a good diagnostician. He sees the patient as a whole. He knows his peculiarities and circumstances. He can decide when to refer him to a specialist and when to protect him against the very real danger which is threatened by a narrow specialist point of view."

It is conceded that the number of physicians, per 100,000 of population, has been decreasing to some extent and that the number of family doctors has materially lessened. The latter is, in part, due to the large number who are taking up specialties. Again, a large proportion of our general practitioners are middle-aged or elderly. During the next decade Nature will take her toll of these which, however, is a double-edged argument. It may result in a continued reduction in number or, as seems more likely, a reaction. Nature has a way of taking care of a vacuum. Pendulums have a trick of swinging the other way. The "premiums" now being offered by many rural towns and villages to attract young doctors, might indicate that, within a few years, the prospects for general practice in the outlying districts will be better than even before. The law of supply and demand is basic and applies even to our profession. The "centralization of medical facilities" will never be realized fully until such time as centralization of our population is complete, and that time is still long distant. In my judgment, too, so long as family life persists, so long will there be a field for the family doctor. He is a sort of human balance-wheel.

Of one thing we may be sure. If the family doctor goes, his place will be filled to a great extent by the prescribing druggist, the patent-medicine vendor, the quack and the charlatan and the various types of healers and heelers. In some communities this has already occurred. In no case has it been a change for the better, and frequently the result has been tragic. Eventually this will be remedied.

Nicholas Murray Butler speaks of the family doctor in

that larger view "which sees the modern physician as the trained man of science and public service, rich in personality, serene and secure in the feeling that others depend upon him, and holding himself for one of the highest and most satisfying services to his kind." To be more concise, the family doctor is not green; on the contrary.

The general practitioner, if he has wisdom, will be aware of his own limitations. He must realize that certain lines of treatment, many operations, properly belong to the specialist and the expert and except in dire emergencies must govern himself accordingly. On the other hand, it is now the fashion to pay homage to the surgeon and to belittle the physician. The mortality from operative surgery might be materially decreased if the physician were given a little more consideration. His training and his powers of observation in many ways differ from that of the surgeon who is ever looking for concrete facts rather than abstract principles. Both are frequently needed to arrive at the whole truth. If the internist were to accept as gospel truth the pessimistic views as to his status, views so freely expressed in our medical journals, he would become disheartened.

"The heights, by great men reached and kept, were not
attained by sudden flight.

"But they, while their companions slept, were toiling up-
ward in the night."

The country doctor has a reasonable chance of attaining height, for he does his share of toiling in the night. His long and solitary drives give him every opportunity for philosophic reflection.

The general practitioner has been to a great extent voiceless, but he is not necessarily dumb. Almost without exception our medical works are written from the institutional standpoint to a greater or less degree. The general practitioner lacks the time and is without the opportunities and facilities which he deems needful for such a work, even

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though he realizes that it must necessarily be limited in its scope. Frequently he lacks the self-esteem or, if you prefer, the self-conceit to attempt the task. If he be worth while, his manifold duties, increasing year by year, keep him busy to the last. He dies in the harness and not uncommonly much useful knowledge dies with him.

It is becoming more and more his duty to his public, rather than to himself, to fight fads and unsound doctrines, to teach hygiene and right living to a wicked and perverse generation, to keep a steady hand on the steering wheel of medical progress. There has been a tendency to too much back-seat driving by the irresponsible. It is pointed out to us that the field of medicine is so extensive, the range of information so wide, that life is so short! We strive to please—to please ourselves, not the back-seat advisers. To listen to them, one might believe their words were on a par with divine inspiration. One of the most dangerous times of life is when one begins to take himself too seriously. Hardening of the arteries is perhaps inevitable. Hardening of the arrogance is, by taking thought, avoidable.

George Ade, in one of his fables says, in effect, that after reaching a certain age we should take a vacation every year, that it does not cost us a cent, since the heirs foot all the bills; that sometimes the heirs object, in which case it is proper to tell them to go and get theirs right where you got yours. For years I have followed this advice, and have been unable to find a flaw in it. I have accurate records of my annual income, running back for many years. One surprising thing about these records is that they show as large a net income for the years in which I took a six or eight weeks vacation as for the occasional years when I was unable to do so. It seems that I am unable to develop more than a certain amount of horse-power in a given length of time and that I return from a vacation with an accumulated reserve of energy for which I find use. Year in and year out it is easier to do a year's work in ten months than the same amount in twelve. The vaca-

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tions have paid all expenses and good dividends in health and happiness.

If we are to accept as gospel truth the dictum of the general medical press at the moment, the general practitioner is about to follow the dodo, the great auk and the passenger pigeon. To quote from a poem on the modern flapper by Walt Mason, " 'You represent,' she said, 'a past that is too dead to skin.' "

Have we already forgotten "the new era" which so abruptly culminated in the fall of 1929? There were false prophets in those days. When specialism is carried to the *n*th degree, the general practitioner will survive. His specialty will be that of a correlator of specialism and of specialists.

If we cut all the branches from the tree of medical knowledge, we will have left only an unsightly trunk, for the time being naked as a pollard but, being well rooted, it will eventually branch out once more. If we remove the trunk of general medical practice, the branches will fall of their own weight, wither, die and decay, ending in a brush-heap which may serve as a retreat for timid rabbits but is otherwise of little use.

For many centuries the field of medicine has been occupied by the general practitioner and, while the "squatter rights" of the specialist should and will receive due consideration and respect, the law that the part is never greater than the whole is immutable.

If I am to judge from what I read in the medical press, we must be, in this locality at least, sadly out-dated and hopelessly old-fashioned. This in regard to fee-splitting. I can say, without any reservation whatever, that when I have operated on cases sent me by other practitioners, no suggestion of fee-splitting has ever been made nor have I ever split such a fee. Likewise, in the cases which, for any reason, I have sent to others for operation or special treatment, I have never suggested such a fee-split and have never received or been offered one.

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Uncle Eph says, "Ye can't make a good job of painting a barn with one thin primin' coat." I make no attempt to cover the whole field of medicine from my own experience. For instance, I do not know a blessed thing about ankylostomiasis save what I have gleaned from a fairly extensive reading of medical literature and I suspect that the authors of some of the works alluded to are in much the same fix, which makes for rather dull discourse. Read 'em and weep, if you can get your emotions so readily stirred. To write what one knows, what one suspects, what one has gotten second-hand and what one doesn't know, would be a dreary task, not only for the writer, but for the writee. On the other hand, a record of, let us say, eighty per cent personal experience and private opinion, might be made interesting, even if not entirely convincing. Which reminds me of the old German who explained why he was only four-fifths German, the remaining fifth being "von vooden leg made in Hoboken."

Some observations need to be stored away, as the years pass, to dry and season. Some metals are improved by burning out the dross. If the reader of this volume has the luck to pick out an occasional nugget of good sense, I will feel amply repaid. On the other hand, some of the belted earls of the profession will doubtless give me a good belt and doubtless it will do me good. I only hope that some of these high Brahmins do not take themselves too darned seriously. The great mogul with his retinue of assistants does not always fully appreciate the conditions which confront the country doctor and the latter is at least entitled to his day in court before sentence is pronounced. Moreover, the general practitioner is frequently a specialist along certain lines.

But they tell us the field is too broad for the family doctor to cover. All right. It's true. So what?

As an offset he is able to supplement the special knowledge of the expert on the disease in question by a personal and intimate knowledge of the family strains, the patient's en-

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vironment, the local conditions, the hereditary tendencies running through various generations. A physician from Brooklyn would not believe that his brother, a resident of our home town, could possibly have typhoid because he had a "normal" pulse of about 75. This was before the day of the Widal and other tests. When I pointed out to him that he had plenty of other evidence and that his pulse was usually below 60 when he was in good health, he saw the light.

We had an old judge who was ailing and the consulting physician gave an unfavorable prognosis on account of a bradycardia or slow pulse, it being 35. To my personal knowledge he had had a pulse of about that rate ever since I had first known him. He died some twenty years later at an age well up in the nineties, still with a pulse of about 35.

Much that is written about the poor old family doctor has the flavor of condescension. We are not necessarily poor; I notice that most people get about a year older every year; and we don't have to limit ourselves to general practice. No one need waste any genuine heartaches over us. We haven't been whimpering so far as I can ascertain and, believe it or not, the family doctor is having as much fun as anyone. Even when he is writing what purports to be a book. Huh! and also Humph!

The general practitioner in the rural districts is frequently obliged to carry on as best he may without skilled assistance or, at times, without any assistance. He should be constructed anatomically after the manner of a spider, with more than the customary number of limbs and feelers. He should be nimble enough to rub his chin on the back of his neck. Lacking this, he should be at least ambidextrous. This can be cultivated. I am naturally righthanded but by persistent practice I am able to use both hands, or either, for most purposes. In fact, I have overtrained my left hand in some ways for I find that for some uses my left hand is much better than my right.

One morning I was called some distance to do a podalic

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version. Two capable physicians had failed to deliver the woman for the reason that they were both right-handed to a degree, and the position of the child was such that it was almost a physical impossibility to turn it save with the left hand. When the left hand was used there was no difficulty worth mentioning.

Some years ago, a man in a buckboard drove frantically to my office. While working with a road-gang some four miles away, one of his co-workers had been sledging a rock. A flying splinter struck another workman in the neck, causing profuse and alarming bleeding. Thinking that, as usual, the bleeding would be stopped before I could possibly get there, I put my emergency kit on the buckboard between my feet and was driven four miles over a villainous road to find one of the workmen making compression over a small punctured wound in the side of the patient's neck. He complained that his thumb was getting tired, as no doubt it was. I procured a wash basin, water, added an antiseptic, got out a few instruments hurriedly. There was only one window in the log cabin which was available, a small window about two feet by three in size. I put my patient on the bed in front of the window and substituted my thumb for that of the laborer. There were some large clots in the loose connective tissue of the neck and, when pressure was relaxed, obviously an active hemorrhage from some deep vessel. No local anaesthetic was at hand, and I had no way of giving him ether. I made a swift cut along the line of the sterno-mastoid, turning out a handful of clots. Immediately a heavy column of bright arterial blood gushed up and boiled out of the wound, utterly obscuring everything. Compression of the carotid from below only partially controlled this. There was still an exceedingly active hemorrhage from above through the circle of Willis. Additional compression from above with my other hand controlled it, but about this time I ran out of hands. To my consternation, when I turned to ask for assistance, I found that, save for my patient, I was entirely alone. They had all

fled to the barn which was some distance away. I shouted and yelled without avail. Temporarily, I felt like a class A idiot.

It seemed to me that something ought to be done about it, but just what I was not prepared to say. There was a stout cord within reach, upon which some dishcloths were hanging. I knew that, with this about his neck, I could control the hemorrhage but had a feeling that the coroner might be captious. Then I recalled having seen in the Wood Museum in New York a specimen showing a ligature around the carotid artery applied by Dr. Charles Phelps. Confronted with a ruptured carotid aneurism, he had held an aneurism needle between his teeth, threaded it with his free hand, successfully tying the carotid above and below, single-handed. This gave me an idea.

Lacking a handled needle, I got out a large, full curved Hagedorn needle, meanwhile controlling the hemorrhage with a packing of gauze in the wound compressed with my left hand. With my right, I buttoned up my coat, which in my haste I had not stopped to remove. I wove the needle through my coat front and found that, by swelling out my chest pouter-pigeon fashion, I could hold it with sufficient firmness to thread a stout ligature through it. With my one free hand I passed this needle just above the clavicle close to the trachea, bringing it out again well back toward the lateral processes. I intended to include everything but the trachea and no doubt succeeded. Using my teeth and my free hand, I tied this mass ligature snugly, puckering up the skin and all the included tissues. I then reintroduced the needle above, following the same line of procedure. I made an earnest attempt to include the base of the tongue, the hyoid bone, the phrenic nerve, and all the odds and ends that might be in that vicinity. With both ligatures tied, I removed the packing, found the wound dry and the bleeding fully controlled.

With a little easy dissection, I found a punctured wound of the carotid, ligated it on either side, removed the mass

ligatures, put in a small silk drain and closed the wound. Luckily, I got a primary union throughout and my patient lived happily ever after. Of course, such things don't really happen, but this did. I cite this case as an example of what we occasionally encounter, hoping that it may serve a useful purpose. This patient owed his life to a happy recollection of the ingenious expedient adopted by Dr. Phelps.

I was called, together with a very capable physician from another town, to a remote country village. A three-year-old girl had inserted a small bean in her ear some days previous. Ordinarily such cases present no serious difficulty, but this one was exceedingly troublesome. The bean had been pushed up against the ear drum, had softened and swelled to some extent and we failed to dislodge it by any of the usual means. We procured some bicycle spokes and, by bending and sharpening these, improvised some satisfactory hoes and spuds.

The child was wholly unmanageable. She was not being hurt, but fought and struggled so that there was danger of injuring the ear and, in any event, it meant several hours of continuous work. A general anaesthetic in so young a child for that length of time involved some risk. The other doctor solved our difficulties by laying her, arms down and snugly wrapped in a blanket, on an ironing board, winding a clothes-line around to hold her securely in position. With her father steadying her head and the aid of a head mirror, we worked in shifts for some three hours, carefully chipping away small pieces of the bean and finally dislodging the remnant, without injury to the drum or the auditory canal. The procedure suggested by the other doctor helped out a bad situation. I had not known just what to do, with the nearest hospital or specialist some seventy-five miles distant. Like a potato, I had eyes but was blind. I could only say, Hamletwise, "For this relief, much thanks."

An old pioneer suffering from chronic emphysema and asthma had, I noticed, a peculiar puckered scar on the right

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side near the nipple, and a very similar cicatrix posteriorly. Naturally this excited my curiosity. I am giving the history in his own words.

"I came from Vermont when I was nineteen years old and went to driving logs on the Salmon River. It was during the spring freshets and lots of times I got wet. I took a bad cold and went into a decline. The doctors all told me I had the phthisic. I was getting weaker and peakedder all the time and I went to an old doctor in Bangor, New York. They all told me he was a good doctor. He examined me, grunted, went into his back room and after a while he came out again with a great big needle shaped like a sickle. It was threaded with a long piece of candle-wicking. He ran that through this place you see in front, between my ribs and fetched it out behind under my shoulder blade and tied the ends over my side. Next two months I ran a pailful or two of thick yellow matter, near as I can guess, but I got well."

The patient, Jonathan Smith, told me this in 1898. He was born in 1802 and was ninety-six years old. If you studied the same arithmetic that I did, you will figure the date of this crude but effective empyema operation as being in 1821. Truly there were giants in those days. If, in my sojourn in the hereafter I should run across this old pioneer surgeon, I trust I shall have grace enough to doff my halo, if any, with the utmost respect for a man who had the courage of his convictions.

It is quite possible that I may never get in touch with him. An old darky preacher was officiating at the burial of a rather disreputable colored man. Nearing the close of his sermon, he felt that he must make some reference to the old scalawag, something of a more direct and personal nature than the general remarks he had made, so he said, "I feels sure that I 'spresses the sentiments of all the brethren and sistren of this congregation when I says that we all hopes Brother Jones has gone where we all 'spects he ain't."

One spring morning a young man was brought to my

office. In getting over a fence his shotgun was discharged, blowing off much of his chin, practically all of his mouth, the front teeth in both jaws, all of his nose and much of his forehead. His eyes fortunately escaped. I built him a new mouth, put two tubes in his nostrils and he got well but he would never consent to my building him a new nose. Some years later he was being cross-questioned by an attorney relative to some illegal liquor-selling. He never drank and stoutly denied all knowledge of the matter, but the lawyer persisted.

"You say you live near the defendant yet you claim you have no knowledge as to what he was doing. How can that be?"

"Because nobody can say that I stick my nose in other people's business."

I was called nine miles in the country at midnight to attend another young man who had cut his throat from ear to ear. He and his drunken companion were in the upper room of a deserted house. We found an old washbowl with a big notch broken from one side, and an old tin sap-bucket. With this equipment and a stable lantern I matched up the severed parts unassisted and took him to the home of his great-aunt, where he made a good recovery.

This old woman was quite deaf and of a crabbed disposition. We would shout in her ear and she would shout back, "Why don't you talk so a body can hear you? What makes you mumble so?"

I spent two hours digging out her ears. The drums appearing normal, I winked at her son and said in a low voice, "Can you hear any better now, Mrs. Keefe?"

"Not a bit better. Not a bit better," she shouted, and hearing her own voice plainly for the first time in many years, and noting our amusement, she rose in offended dignity and swept up the stairs to her room.

XV

SPECIALISM

ONE day I pushed the button on the minister's doorbell, not that I had really acquired the habit, but just because. Getting no response to this or to my knocks I walked in, knocking at the door of his study which was in the wing. I told him his old buzzer was on the blink and he said he knew it; that one electrician had adjusted the bell and buzzer, another had put in a new dry cell, another had tightened up the connections and a fourth had scraped the pushbutton contacts. In each case the bell had worked for a short time. I found a long string of wires running from the wing into the main body of the house, then through the cellar across the house to come up once more to the first floor and the front door. This was operated by one dry cell. I suggested that he put on an additional cell which ended his bell trouble.

I have seen many patients who were improved by various operations on this and that but who got no really permanent results until their voltage or amperage or both were increased by *tonics* and *restoratives*. Ill health may be due to a break in the coil or something that requires the services of a skilled electrician. On the other hand, if the battery is weak or exhausted, while this is readily remedied, no amount of local tinkering will be of permanent benefit.

At the time the Roman Empire was in its glory, Galen writes, "Rome swarmed with special curers. Some, for instance, confined their practice to diseases of the uvula, or the eyelashes, or certain kinds of cutaneous eruptions. Some restricted their attention to the treatment of aged men, others to that of the strong and robust. Some would cure only with herbs, others by means of gymnastic exercises."

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We hear that this is the age of specialism, that the general practitioner is doomed. Perhaps I am a chronic optimist like Uncle Eph. Before he rented out his farm and started his garage business, he was, like most farmers, something of a horse trader. The prospective purchaser of the roan mare asked her age. Eph said, "I don't exactly know just how old that there hoss is. I jest bought her yestiday from Si Perkins. *He* says she is sixteen but you know Si jest as well as *I* do. He's sich a dad-blamed liar you can't believe a word he says. She may be only six or seven for all *I know*."

Kipling says in his *Song of the Banjo*:

"I'm the Prophet of the Utterly Absurd,
Of the Patently Impossible and Vain,
And when the Thing that Couldn't has occurred
Give me time to change my leg and go again."

I always did like banjo music and have no objection to the other fellow changing his leg. I also like applesauce, some kinds, at least. But this is the age of specialism and the family doctor is doomed. Huh! Some of our brethren will need a change of leg before they go again.

Let me reassure you. I have the highest regard for the real specialist. A very large proportion of the advances made in medicine and surgery are directly due to those who have made a special and intensive study along definite and circumscribed lines. The general practitioner and the specialist have each their legitimate field of endeavor. Neither can hope to cover the whole field but each can at least have a good general knowledge of the other's line of work. On the one hand, the general practitioner who tries his hand at cataract extraction has criminal instincts. On the other hand, the skin specialist who begins his chapter on eczema with the statement that "Eczema is a dermatitis having its origin in a variety of local irritations. The old theory that it is due to some underlying dyscrasia has long since exploded" should hear some of us explode when we read it. True it is that

scabies involves only the cuticular layer but, with such a specialist, it is oft-times gross flattery to say that his knowledge is merely skin deep.

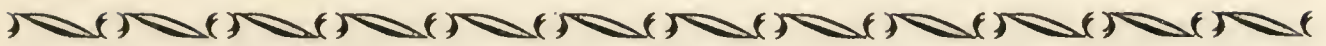
"Eyes have they, but they see not." At least the broad highway of general practice gives a better view than the limited alleyway of specialism. As for old theories, we have lived long enough to see many old theories rediscovered. We are too prone, in discarding old ideas, in grasping at new theories, to consider the ancients as something like foreigners, a little less than human. We are prone to forget that we will, ourselves, be ancients quite soon enough and that we are foreigners indeed to the inhabitants of other lands. We should remember that human nature, basically, is much the same the world over and adown the centuries, that no age and no locality has a monopoly of knowledge or wisdom and that it is unsafe to be too dogmatic in anything pertaining to the practice of medicine.

Coleman Cox says, "I believe that every minister should have been a dawgone good sinner for at least ten years before starting out to preach against sin." Some such line of reasoning is not inapplicable to the specialist. Goethe once said that one of the most interesting books that could be written would be a treatise on the errors of mankind. Let us take heed that our errors do not unduly swell that book. The specialist will avoid many pitfalls if he spends a few years in general practice before taking up specialism. The general practitioner will avoid many errors if he sends his unusual cases to the specialist. Some swords cut both ways.

There is an essential difference between a natural mistake and a mistake of nature. The point I am endeavoring to make here is merely that we are all human. We all make mistakes but the wizardry of the specialist is more spectacular and better press-agented than that of the small-town family doctor. We need each to supplement the other and urgent needs have a way of being satisfied. A certain measure of charity in either direction does not come amiss.

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Some have the temperament and the genius of the true artist; that joy in perfecting themselves along one line, in doing some one thing better than their fellow-workers. To such we can only give our blessing. Go to it, gentlemen, for ye are the salt of the earth!

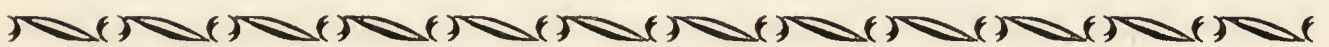


XVI

THE SPECIALETTE

“Hear you this Triton of the minnows? Mark you his absolute shall?”
Coriolanus, Act. iii

“And the little dog laughed to see such sport.”
Mother Goose



BUT in contradistinction to the real specialist, whose position is unassailable, we have a large family of pseudo-specialists (Specialissimos, Near Specialists, and Specialettes); some belong to the genus Liliaceae, others to Orchidaceae, Labiatae, Oleaceae, Prunus, Meibomia (my abomination) etc.; the various species, numerous variants, occasional “sports” are familiar to all of us. It has been written that “The fair city of Minneapolis hath ever, according to ancient writ, been a thorn in the flesh of St. Paul,” and this group is verily a thorn in the flesh of many of us, including, we are fully convinced, the specialist proper. The ordinary specialette, *S. Communis*, bears about the same relation to the true specialist, in relative worth, as pop-corn does to the maize crop as a whole.

My old friend, Dr. S. J. White, of Franklin, New York, wrote me as follows:

“While it is a poor boob who hideth his key in a napkin, who burieth the few talents he may possess, the specialissimo standeth upon tip-toe that his dignity may yawn: he smiteth himself upon the breast and saith, ‘Verily I am It,’ and too frequently the public taketh him at his word. Of a truth he hath a pink heart like that upon a valentine. Dryer than the Gila Valley in the Year of the Great Drouth are his epistles, yea, as drab are they as a fleet of mudscows painted a battleship gray, on a foggy morn. Though he hath

added unto himself more degrees than a thermometer, he is verily as a reed shaken in the wind when he meeteth up with one afflicted with a sore distemper. Of a verity he becometh so distended he should run up the Euphrates and spawn. He hath a single-track mind and in good sooth needeth a score of switches lest a head-on collision befall him. So it seemeth at least to us rude fellows of the baser sort — or would basic be a word more meet?"

Dr. W. P. Shrewsbury writes me,

"So long as human nature shall be what it is, so long will it be hardly possible for a man to devote himself to one thing without losing more or less of his general view. . . . His specialty, no matter how important, is only a side-show in the practice of medicine and he, no matter how brilliant he may be, is only one of the agile tumblers in that side-show. . . . He is like the man with an opera glass at his eye. He sees with unusual clearness the actor on whom his glass is turned but he sees little else. As for the audience, he is hardly aware of its existence but, at the same time, he is merely a unit in that multitude, any other unit of which may be as good and as intelligent as himself."

Despite the fact that he makes no mention of the snake-charmer in the side-show, the context clearly indicates that he was writing of the specialette, *S. Seriosa*. But why break a butterfly on a wheel or, to change the metaphor, why give 'em Hell when a puff of insect powder is all that is required?

Specialism far too often affords a haven for the lazy mind. *S. Communis* commonly runs true to type. The incompetent, unable to stand the gaff of general practice, seeks refuge and becomes a "specialist," self-styled. Such specialettes resemble silver-plated table knives. They look brilliant but are insufferably dull. Wodehouse suggests that one tonsil or something may be missing or they may merely be fluffyminded. One of my patients recently returned from a visit to the city where she had fallen into the hands of a special-

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ette, *S. Trivialis*. The letter of advice, which he sent later, reminded me of the parody of Kipling's *L'Envoi*,

“And he paints the Thing as it isn't
for the God of Things as they Ain't.”

Some cities appear to be pediculous with specialettes. In particular with that poor lizard, that insignificant squirt, *S. Foetidus*, who, after a season of riotous living in Paris or Berlin, has acquired a rich modern medical parlance, a pseudo-scientific vocabulary or (*S. Diffusus*), a patter of polysyllabic words and, choking with knowledge, dubs himself a “specialist.” He is a known authority because he admits it himself. His name is emblazoned in *Who's Who*, likewise in *Is That So?* and in *What of It?*

We must admit that the specialette is dead right at times. Even a clock that is not going is dead right twice a day. But, Lord! How they do bore us at society meetings! Our friend, Pope, wrote some years ago,

“Fire in each eye and papers in each hand
They rave, recite and madden round the land.”

And another friend wrote even more years ago,

“*Parturient montes; nascetur ridiculus mus.*”

I saw and heard one of these dignitaries, *S. Spectabilis*, at a society meeting not long ago. He had a string of capital letters after his name and was obviously a big man in his way, not to say bulbous or distended. Our comparatively dull minds were illumined and exhilarated by the scintillating coruscations of his intellectuality to such a degree that we grew vertiginous. After this personage had taken his departure and the dazzling effect was becoming less pronounced, one of our local doctors (having taken notes of one sentence containing just 162 words), crudely suggested that the speaker had been inebriated by the exuberance of his own verbosity. Another postulated the theory that his address

was the most exalted example of exhibitionism so far recorded, while a third said in an awed undertone, "Hush, man, you should show proper reverence for God Almighty's Oldest Brother." After some discussion this informal jury agreed on a compromise verdict that it was not merely talk for talk's sake; that he was probably a throw-back to some of his gene-bearing chromosomes; that there was no culpable negligence proven since he probably had no other way of expressing himself. Anyway, slowly reverting to our usual manner of speech, he was some chromo.

It saddens me to think that many of these specialettes are mentally penniless and destitute and that their vocabularies so commonly outrun their ideas. Having little to say, they say it with a ponderous circumambuloquacious ambiguity and redundancy that is wearisome. I have just finished reading an article in one of our journals by this variety, *S. Simulans*. It is so filled with references to the Proceedings of Certain Foreign Societies, so replete with Polish, Russian, and Czechoslovakian proper names that I defy anyone to read it out loud without feeling as if he had a lump of alum in his mouth. It was a good article, however; I know this because I felt so good when I had finished with it.

"Who was the first man?" asked the teacher.

"George Washington," answered the pupil.

"No. You are wrong, Georgie. Adam was the first," said the teacher.

"Oh, well, if you are going to count foreigners," Georgie grumbled.

Occasionally one of these near-specialists, *S. Conspicua*, like a geranium plant does rather well, even if kept in the front window all winter. Still, unless one turns it round occasionally, the plant becomes asymmetrical, the leaves all facing one way. It looks lovely from the front but, from the rear, is comparatively unattractive. Unless the specialette has been rounded out by general practice, he shows this tendency.

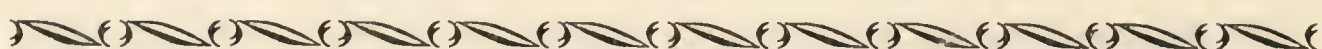
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Hysterectomies for uterine fibroids, which occasionally turn out to be simple pregnancies, are seldom laid at the door of the family physician. The practice of removing tonsils for a persistent cough, when the merest tyro would have found a lung cavity, is not to be commended. To our minds, the young lady who paid for expensive radiation treatment of her sciatica, when it was later shown to be due to pressure from a pelvic tumor, has been ultra-violated, albeit only in the 2d or 3d degree. The general practitioner who sends a case of ureteral colic to the hospital for an X-ray and has his patient returned to him (without plates) with a diagnosis of "no stone," may feel a bit chagrined but, when the patient enters his office a few days later with a renal stone in a discarded pill-box, a stone which passed *per vias naturales*, he recovers his equanimity.

I happen to know of a number of cases of "appendicitis" that were saved from a laparotomy, simply by correction of errors of refraction which were causing the reflex disturbances. One lady, sent to Montreal for removal of a pelvic tumor, changed trains at Huntingdon, Quebec, and consulted me. Three ounces of castor oil enabled her to go back home two days later, minus her tumor and ten dollars.

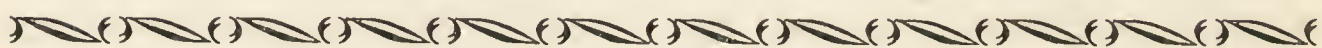
Taken as a whole, there is one good thing that can be said about the whole genus of specialettes; this is that they do not all sting us in the same way and in the same place. Mostly they are stuffed shirts. Yessir. I know that the phrase is slangy and that it will be objectionable to many. One of my sole and only excuses is that it conveys a definite meaning better than any other within my present mental grasp.

It is my fervent hope that the time is still far distant when we shall have a specialette who confines his services strictly to diseases, affections and derangements of the right lower border of the left nostril in persons of the masculine gender who are over 27 years of age. Or a near-specialist who limits his practice to prescribing gin rickeys for the left kidneys of brunette bassoon blowers.



XVII

THE THERAPEUTIC NIHILIST



AFTER a fashion, I have a measurable admiration for that bird, the therapeutic nihilist. I admire his courage, fixity of high purpose and a lot of other eminently desirable qualities. Otherwise, to continue the practice of medicine, armed only with a three-drug outfit and a languid eye, must be as wildly exhilarating as the clam races the children used to stage on the beach. They would drive down two stakes some twelve feet apart and arrange a row of mussels on a line between the stakes. On the following day it would be found that some of their speedier favorites had moved as much as three and one-quarter inches in the preceding twenty-four hours.

They have unquestioned courage. It requires this virtue to continue in practice, year after year, with only an emasculated medical gospel for guidance. True, the nihilist, expecting nothing, is seldom disappointed. This may be an aid, since repeated disappointments tend to discouragement. But he is just naturally courageous. If you doubt this, pick up almost any catalogue of medical publications and take a squint at the photogravures of some of these nihilists. You will be compelled to admit that most of them have courage of a high order, or they would not permit their photographs to be thus broadcast; others appear to be merely 22 cal. camouflaged; a few resemble, as Wodehouse puts it, "Something that crawled out from under a flat stone," or look like a fish that had gone wrong. I fondly anticipate that I am likely to shock some solemn asses who will utterly disagree with me.

Some nihilists doubtless have a true aim, but this, with blank cartridges or an empty magazine, is merely a big bluff. Most of us prefer to have it backed up by a bunch of high-

powered cartridges. Otherwise we feel on the edge of nervous prostration or nervous prostitution — something along that order. Why is a medical nihilist, anyhow? Has he forgotten all he ever knew? Or did he ever know it? It was Richard Harding Davis who was sent as a newspaper correspondent during one of the Latin-American revolutions. Upon arriving at the hotel in a cab and registering, the hotel manager asked Mr. Davis how many pieces of baggage he had with him. Mr. Davis told him he had fifty-four pieces — a pair of extra socks and a pack of cards. He doubtless had reasons for his limited equipment.

Faith in drugs and remedial agents, knowledge as to their action and judgment in their use, take up but little space, are easily transported and do not constitute perishable freight. Why deny one's self these things, when the freight rate is not excessive? Somehow the nihilist reminds me of the young chap or chappie in one of Wodehouse's tales. You know. The one whose best girl told him that he "appeared to know less and less about more and more, from day to day." Some of these nihilists retort that we overdose our patients with unnecessary drugs. If overdosing is wrong, is underdosing any the less wrong? The medical nihilist is a fatalist.

Personally, and speaking solely for myself, as it were, which is a redundancy and quite as needless as the overdosing referred to, I feel sure that the man who believes he can, commonly makes a mighty close guess. Per contra, the man who thinks he can't is licked at the start. The worst is not to try. If I have no faith in myself or in my curative agents, I find myself at a loss to inspire it in my patients. Some of them are not as dumb as they may appear. We all know what faith, or the lack of it, can do to a patient. True, if you do not feel that you can prescribe anything for your patient which will be of the slightest use, you can always find some records which will prove indubitably that such attacks do or do not, as the case may be. You can comfort and console him with this form of dry diet which, if not nourishing, is

at least very filling. Still in all, I have a feeling that, as someone expressed it, a man caught out in a heavy rainstorm is not fully content with statistics showing the average rainfall in that particular locality. What he really wants is an umbrella.

Fate has been kind to me so far, but I suppose that even fate is entitled to an occasional day off or even an off day which frequently amounts to the same thing. I have a premonition, a presentiment or possibly a common and vulgar hunch, that if I am ever seriously sick and have one of these medical eunuchs to look after me, I will wake up listening to the angel choir, this of course if I am still an optimist regarding my future state after the book reviewers get through criticizing this first and presumably sole edition. Anyhow, I would like to have my doctor do something for me, any old thing, if only for the psychological effect. The mere effort might cheer me on my way.

The other day something went wrong with my car and I had Uncle Eph come over to look at the ignition. I asked him if he thought he could put it in running order for me as I would soon need to use it. His whiskers twitched a little and I noticed a slight, transient ptosis of one eyelid. He said, "Ye kin do most anythin' if ye know how." He had it in running shape in about five minutes so I am suspicious that there was nothing much really wrong with it. To me it had appeared to be a case of total paralysis. At any rate, he did something to it and it made a rapid recovery. There is no moral to this.

Once, when in Savannah, I had occasion to go to the baggage office to see about a trunk. It was noon and there was only a negro porter in charge. When I entered a complaint about my baggage he said, "Boss, this yeah baggage company don't consume no reliability for anything dey handles." When a patient puts his trust in me, I do not want to be an intellectual jellyfish, to feel incompetent, irrelevant and immaterial as our legal friends put it.

Some of the paragraphs in this chapter have a strangely

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reminiscent sound. Some of it may be plagiarism, conscious, unconscious or subconscious. If so it would not surprise me in the least. Some things are not worth appropriating, others will bear repetition, and the originator of a real thought loses nothing thereby. He still has it and should not feel aggrieved if his friendly neighbor considers it worth repeating.

My own opinion, which however, has not yet been proven by post-mortem findings, is that the medical nihilist has pernicious anaemia of the intellect.

XVIII

REVISING OPINIONS

OPINIONS, views and theories shift from year to year. It is unwise to subordinate facts to theory. This is not a new idea but, like the Lord's Prayer, is worthy of respect. Facts are unalterable though their interpretation may give rise to controversy. Only those whose views and opinions are no longer fluid but have become frozen assets — or liabilities — need chloroforming at the age of forty. When a man can no longer change his mind, swiftly if there be need, the Yankauer mask may be of service. We are told that it is a woman's privilege to change her mind. Doctors should be allowed similar latitude. We are, or should be, constantly revising our ideas if we, and the opinions which we hold, are worth while.

As a medical student I was taught that alcohol was a necessity in the treatment of pneumonia, of typhoid fever and of many other conditions, and for years I prescribed it in accordance with the prevailing views. As time passed my faith in its efficacy slowly diminished. I found myself prescribing it less and less; now I seldom give it. I am not a prohibitionist. If I have a patient who has kept himself loaded to the Plimsoll mark and he is stricken with some serious illness or meets with some grave accident, I give him plenty and my conscience troubles me not one whit, whatever a whit may be. Irrespective of prejudices, preconceived opinions, personal desires, I think that we all know that alcohol has done more damage than good, on the whole. Some of us are not frank enough to admit what we know to be the truth. I believe that I have seen some lives undoubtedly saved by it, but I *know* that I have seen a great many lives lost through it.

It is the fashion just now to attribute our present lawless-

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ness to the after-effects of the 18th Amendment. The same sort of logic would indicate that, if we repealed the Ten Commandments and abolished the Scriptures, the Christian world would be without sin. This is an age of speed and efficiency. We are essentially motorized. We must remain sober or put Hell on wheels. Nevertheless, it affects the doctor acutely. The man who drives a motor car while more or less intoxicated is a criminal. He is gambling not only with his own life but that of others and he should be held directly responsible. A headless body, a thoracic cavity pierced by a guard rail, an eviscerated abdomen, the protruding bones of a compound fracture, the bloody mutilations which we encounter have aspects too horrible for detailed description to the public. But the doctor, good Samaritan that he is, full of pity, full of compassion, leaves his other patients, cleans up the awful mess and seldom gets even thanks from anyone. But, "Doctors like that sort of thing," I hear someone say. Name me one. Acute motoritis complicated by alcoholic cerebritis constitutes a public menace. This is, of course, only one facet of a question which has many angles.

Time was when I considered pneumonia a disease whereas I am now convinced that it is a mere pathological condition attendant on many diverse infections. Rheumatism, dropsy, peritonitis and many other ailments, are no longer considered distinct entities. In my student days, forty per cent of locomotor ataxia cases were attributed to syphilis. I said then that one hundred per cent would be nearer the mark. Today, ninety per cent is conceded. The remaining ten per cent has simply not been found with the goods. To all appearance, then and now, it is merely one phase of syphilis of the spinal cord. It is of course possible that some other infection may give rise to a similar degeneration.

I once considered Huntingdon's chorea a typical illustration of a well-defined and distinct disease of the nervous system. An intimate knowledge, running through five generations, of a large family with its various branches, has to

some extent changed my mind. Many members of this family have had retarded development, congenital idiocy, dementia praecox, cyclical attacks, melancholia, mania, catalepsy, hysteria, epilepsy, trance and various forms of cerebral degeneration, some of which I have been unable to classify. The most constant manifestation in this family group has without doubt been Huntingdon's chorea but I have also seen cases of Sydenham's chorea as well. Choreas in this group, which responded to the customary treatment of chorea major or made a full recovery after I removed infected tonsils, can hardly be considered any more hereditary than a cork leg. For these reasons I do not now feel that hereditary chorea is a disease in itself. There must be, however, some underlying factor which is undeniably hereditary, else why should the tendency run through generation after generation? Call it a neuropathic tendency if you will. Giving it a name affords little explanation. As for naming the trump myself, I pass.

One occasionally wonders just what relationship, near or remote, there may be, if any, between epidemic cerebrospinal fever, encephalitis lethargica, and acute poliomyelitis anterior, now that the latter is no longer considered "infantile" paralysis. Our pathologists and bacteriologists are barking hotly on the trail and getting close to treeing their quarry. I recently saw a case which presented symptoms about evenly divided among the three. The experts called in were unable to come to a definite decision. Mere involvement of different nerve centers and nerve tracts does not necessarily preclude a common factor. As "Chick" Grattan says, "If it had been a little colder last night, it would have froze harder," which is indisputable. With further investigation we will have greater knowledge. Meanwhile, we are slowly making progress, "Half steam ahead, by guess and lead, for the sun is mostly veiled—" as in Kipling's *Rhyme of the Three Sealers*."

XIX

HOSPITAL PROPAGANDA

AT THE present time and speaking, as usual, from the standpoint of the country practitioner, the view that all tonsillectomy cases and all maternity cases, for instance, are properly hospital cases and should receive institutional care, seems untenable. It looks like a counsel of perfection rather than a practical working program. Theoretically this is desirable—a consummation devoutly to be wished. As an ideal concept, it has unquestioned merit. As a realization in the near future it seems hopeless, else marriage will be a lamentable failure. We might, of course, make divorce compulsory instead of leaving it optional, as at present. We might change the conventional, “And they lived happily ever after,” to, “And they lived happily for several weeks.” If this view holds, it must also follow as the night the day, that an undue proportion of infected or hypertrophied tonsils remain unharvested.

We cannot materially alter conditions by advising people to do the impossible. I understand that there was once a bill introduced in the Legislature to abolish the high winds in Kansas, or was it to limit the prairie zephyrs to the first Tuesday following the first Monday in each successive month, like directors’ meetings? My memory must be failing, for I do not quite recall which it was. But never mind. It was about as practical as jacking up the rear end of a Cadillac by inflating a pink toy balloon. Some of my readers who follow the rule, “Don’t ask ’em. Tell ’em,” may not agree with me. Uncle Eph says, “The feller that you can *drive* ain’t gen’rally worth the trouble.”

My own personal, private and strictly confidential opinion is that the family doctor — pitiable old wreck that he is —

need not worry about it for some years to come. If this be treason, lese majesty, malfeasance in office, contempt of court or mere baloney, make the most of it. Theories or opinions, on either side, break no bones. Despite baleful glares to which I have painfully acquired a measure of immunity, I shall let these statements ride. Most of them were borrowed anyhow.

In a comparatively recent survey of the schools in a small town of some two thousand or more inhabitants, I found two hundred and fifty-six children who apparently needed tonsillectomy: only a relatively small proportion of these could pay for operation. The town, with direct taxation running from six to eight per cent, would make no appropriation for this purpose. The State made provision for my doing a large number of tonsillectomies on the adjacent Indian Reservation but none for the white children in the town referred to. In such cases it frequently falls upon the local doctors to take up this white man's burden. To their credit, be it said that they commonly do so. Usually some local surgeon develops an aptitude for the work and, partly in his capacity as a surgeon, partly as a missionary, he holds throat clinics and operates on many of these cases for a merely nominal fee or, if need be, for no fee at all. Moreover, his work, both as regards thorough enucleation and freedom from accidents and complications, will usually stand comparison with that of our well-equipped hospitals. Skill and brains are where you find them.

Until such time as our State Welfare or other authorities are enabled to provide a capable housekeeper to take the place of the mother while she is in the maternity wards of the hospital, many a mother will prefer to remain at home during this trying ordeal rather than leave her numerous young children in an isolated farmhouse without adequate supervision. The length of time in which the maternity case must be in the hospital cannot always be determined in advance; neither is it usually possible to fix upon the exact time of confinement with the accuracy and precision of Joe Martin. He

came after our weary Doctor Jenkins late one stormy mid-winter evening. Careful inquiry on the part of the doctor elicited no trustworthy evidence of approaching labor save Joe's urgent protest over any delay. "What was she doing when you left home?" asked Jenkins.

"She was sitting by the kitchen stove mending my pants," answered Joe.

"In that case why are you in such a hurry calling me?" asked the doctor.

"But, Doctor, her time is up at twenty minutes to eleven," and the outcome of the case seemed to verify Joe's stand.

Should the ideal concept, alluded to in the beginning of this chapter, ever be realized, I would suggest that, in view of the rapidly rising cost of maternity cases, each newly wedded pair be presented with a neatly framed motto, suitable as a companion piece for the marriage certificate, entitled, "Don't start anything you can't finish." This may not be necessary for those liberally endowed with blue-chip stocks in a bull market.

As regards many other cases sent to the hospital, it too frequently happens that this thoroughfare proves eventually to be a one-way street. It too often occurs that the family doctor, who sends a patient to the hospital, never hears, except indirectly, anything further in regard to his patient. If he sends his patient with a written history of the onset and course of the trouble together with other needful information, it would seem that he is entitled to the courtesy of an acknowledgement. It should be assumed that he has a keen and very human interest in the case, in what was found at the time of operation or even in the post-mortem findings. Considered from the coldly scientific aspect, he should benefit by having his diagnosis confirmed or by having his error corrected.

It is no more than just to say that the vast majority of our hospital men are courteous and scrupulous in this respect, which makes for a kindlier feeling toward hospitals in gen-

eral. A small minority, some through carelessness, others through indifference and occasionally one with an eye to the main chance, do an immense amount of damage to a good cause. They should be more considerate. One eminent naturalist says that the rabbit is designed by nature to furnish a food-supply for animals of a higher type. Be this as it may, a large proportion of the family doctors are not of this bunny make-up and are good scrappers when they are aroused. I have no doubt that in time the relationship between the general practitioners and the hospitals will be much better coördinated. Neither can be wholly successful without the whole-hearted assistance of the other and it is a great pity that the acts of a few thoughtless individuals should arouse any antagonism. There can be little question in any reasonable mind that it will be much better for all concerned when hospital facilities are provided for all who need them. At the present time this is (save to a limited extent) not possible in the country districts. It is stated that forty per cent of the counties throughout the United States have no hospitals. It will take time to educate the public, billions to provide the necessary facilities, vast changes in our present social structure and much patience on the part of all of us, before that desirable end can be attained.

Meanwhile the equation is unfinished and we can only hazard a guess at the final result. From the point of view of the small-town doctor, hospital costs are high and will tend to increase rather than decrease as new methods come into use and new appliances are required. It is essential that the smaller communities should conserve their limited funds by having minor affections treated in the patient's own home in order that the major cases be provided with proper institutional care. Here the health authorities and the social welfare officials have a huge field in prevention and relief. Hospitalization at the present time is not a problem for the rich nor for the poor but for the middle classes. This is equally true of our group clinics. Preventive medicine involves, in a large

measure, early diagnosis and here the level-headed general practitioner has one advantage — he is Johnny-on-the-spot.

The theory that the family doctor is now going into the discard and that the hospital will soon take his place, sounds suspiciously like the theory heretofore referred to. The new era of universal prosperity and the abolition of poverty, so much stressed in the earlier part of 1929, took a bad fall. The present one relative to the more abundant life seems to be getting a bit wobbly. Many a happy dream is dispelled by the cold gray dawn. Meanwhile, the general practitioner, recognizing his responsibility to the community which he serves, goes about his business undisturbed. I said something of this to one of our city doctors, an internist of the glossy type, and he immediately became snooty, apparently unaware that I habitually wear a snoot-proof vest.

Quite recently a typical hospital internist, a man of deservedly high standing in the profession, while pointing out the difficulty in making a differential diagnosis between kidney nephrosis and nephritis, referred to a case then under observation. "In my own hospital the first diagnosis was tubercular meningitis, prior to which, in another hospital with which I am connected, the diagnosis was encephalitis lethargica. Before he was hospitalized he had a consultation of several general practitioners and *none of them had any idea of what ailed him.*" The italics were his. Call the umpire.

Errors are common to all of us. He seemed to think that this was a huge joke on the general practitioners but it reminded me of Dr. Jenkins who met several other physicians on an obscure case. They could not agree at all and Jenkins did not volunteer his opinion. When pressed for his view of the case he said, "I don't know what ails this man and I'll hit it closer than any of you." The joke in this case was that he actually did.

There is another phase of this matter. The family doctor has an active personal interest in little Jackie Smith whom he has known since the time when, at the age of exactly noth-

ing, his nose was obstructed with mucus. Jackie is not merely "a case" where the main interest lies in the question as to whether his kidney trouble chiefly affected the stroma or the glomeruli, although the doctor may be quite interested in that also.

It would be unfair to expect the hospital surgeon to remember always that the "case" is someone's only beloved son or someone's adored mother who is facing death. It is one of the inescapable attendants on mass production. The human side is lacking, but much can be said for this impersonal attitude. Judgment should not be unduly influenced by the emotions.

Occasionally some patient returns from the hospital complaining of the food, of the doctors and nurses, of lack of sympathy on the part of the attendants, etc. I tell them that we are all human whether we are engaged in hospital work or in private practice; that a little consideration *on the part of the patient* does not go amiss with an overworked doctor or nurse.

A very nice and lovable girl in our village had to go to Montreal for removal of a large ovarian cyst. Her mother was an invalid and could not go with her. She knew no one in Montreal and naturally dreaded undergoing the ordeal among strangers.

I said, "Nellie, I will give you a letter to the doctor and I will guarantee that you will be mighty well treated," giving her a note carefully sealed.

Upon her return she was all smiles. "Oh, Doctor Macartney, the doctor and the nurses and everyone were so gentle and kind and good to me! I've been wondering ever since I went there what it was you wrote in that letter that made them so nice to me. Will you tell me?"

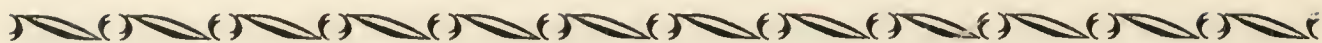
I laughed and said, "I started you off right. I merely told the doctor that he would find you a very nice patient. You did the rest yourself. You were nice to *them*."

Quite frequently, when I send some patient to the hospital

for operation or special treatment, she pleads poverty and asks me to use my influence with the hospital surgeon or specialist to get a reduction in his fees. When I am in doubt I make it a rule to ask her in a casual manner if she will need a private room or a special nurse. Commonly she assents to this and I always tell her that such things are luxuries and that the hospital attendant would, quite properly, pay no attention to such a request.

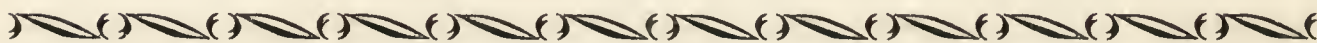
When a patient is really in financial straits I have no hesitation in making such a request and, to the credit of the hospital men, I want to go on record in saying that in every instance which I recall they have been more than kind and generous.

With the advent of good roads and speedy transportation, I notice that, in certain towns, it is becoming more and more the custom to drive to the nearest medical center for treatment. During the winter months in our north country I likewise hear many bitter complaints from the inhabitants of these same towns of the increasing difficulty in getting skilled physicians to settle in their communities. This attitude is wholly unreasonable. Why should they expect local physicians, most of whom are capable and trustworthy, to take all the hard knocks during inclement weather and be content to treat only trifling and minor cases during the remainder of the year? They must make their choice and abide by it.



XX

THE DEAD-BEAT



A PASSING motorist saw an Adirondack guide stretching four deer skins to cure. He remarked, "Well, I see you got four deer."

"No," said the guide, "only two. One of them had three hides."

It has been said that, for all practical purposes, doctors are the only mammals that can be repeatedly skinned.

Most animals get slightly peeved when the second and third layers are removed and even doctors feel that way. It gets down to the quick. That bird, the chronic dead-beat, is of brass, brazen, with but one principle he holds inviolate, never to pay that easy mark, the doctor. Insensitive, rebuffs fail to discourage him. He tries all the doctors and is very trying to us. He reminds me of the little darky in the hospital who was caught using a tooth brush, the very personal property of the head nurse. In extenuation he said, "All tooth brushes tastes the same to me."

The dead-beat swears by the beard of Abraham, by the sword of the Prophet, by the clasped hands of Buddha, that he will pay you on Saturday night but, in his calendar, there is no Saturday night. He has a peculiar form of one-sided amnesia. Forgetfulness is strictly confined to what he owes you. If it is the other way round, his memory is excellent. The dead-beat may be very well in his place but, unfortunately, he never gets there until he dies and the waiting is so tedious! Some people profess to believe that there is no Hell but, if this is true, what an injustice to those who pay their bills promptly!

Old Ame Merritt's wife was prone to melancholy. One

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day she saw our sculptor of gravestone marbles driving by with a monument in his truck. Forthwith she started to brooding on shrouds, caskets, cemeteries, obituaries, tombs, and (this being before the time when morticians were invented) "undertakers," and such paraphernalia attending death and dissolution. In the early morning, worn with anxiety and grief, distressed by loss of sleep, she could not bear it any longer; she nudged Amos repeatedly until his snoring ceased, and wailed, "Ame, what kind of a stone do you think I'll get when I die?"

"Brimstone, ye blamed old fool, brimstone," said Amos and resumed business.

Cathell says that there are three kinds of poor people, "God's poor, the devil's poor and the poor devils." The first are seldom allowed to suffer for lack of a doctor. We can take a chance on the third, but the devil's poor, in other words the dead-beat, should be told to go and jump in the bosom of the billowy Atlantic. No ordinary creek would hold all of them.

Night before last one of these fellows wanted me to take a long trip to see his daughter who had hysteria. I had a judgment against him over thirty years old, an outlawed note, an unpaid ledger account, (the third hide). I said, "Begone," and in the language of Irvin Cobb, he be-went. I did not find out where.

Old Archie McCann was a miserly chap who lived like a pig in a sty. He died at the age of eighty-four. As I was returning home on this occasion, I passed Uncle Eph who was at that time running his farm. Eph was pumping water into his cattle trough. "How is old Archie this morning?" he asked.

"He has just passed away," I answered.

"Well, well, well. Poor old fellow. Well, he's *better off wherever he's gone*," and kept on pumping.

Sandy McNab was passing Angus McLeod one day and said, "And did you hear the news, Angus?"

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"No. What news?"

"Jock McKillich was arrested for stealin' a cow."

"For stealin' a coo! Och, the poor daft fool! Why did he no' buy it and no' pay for it?"

To be charitable is one thing. To be accessory to a camouflaged theft is a wholly different matter. The world system of affairs in general is founded on the basic law that everyone must keep his word good, must pay his debts and meet his obligations so far as in him lies. A little reflection will show that without this fundamental law which, for lack of a better name, I call the law of social responsibility, all business would come to a dead stop. How could we mail a letter, buy a bill of goods, send a telegram, ride in a railroad coach? If we did not pay in advance no one would listen to us. The man who is tricky and tries to beat the game is, after all, the exception which proves the rule. He may succeed for a time but he is swimming against a steady current which eventually exhausts him.

One old pensioner owed me a large note. He sold his farm, and made over all his property to his wife, figuring that I could not touch his pension or the proceeds thereof. He had overlooked a few things and I levied and collected in full. He squealed like the cornered rat that he was. He reproached me for making all that expense and trouble for a brother in the same church. I told the sanctimonious old rascal solemnly that I was doing my level best to follow a scriptural text which I had in mind. "Behold . . . how that the Lord had delivered thee today into mine hand." (I Samuel 24.)

One farmer who, with what he had gotten honestly and otherwise, was quite well off, owed me a bill. Busy with my practice, I sent him an occasional statement, when the roads were blocked. The bill ran over the six year limit, and a neighbor told me confidentially that the farmer had said it was not collectible and that he did not intend to pay it. I thereupon sent him another bill with the curt demand that he come to see me. As I anticipated, he came in a rage, de-

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manding why I had charged him for an operation I had never performed. In the presence of my bookkeeper and clerk I blandly apologized for an error which I could not well explain in any way except a similarity in names. I asked him if the balance of the account was all right, which he admitted. I crossed the objectional item off and asked him when he was going to pay me. He said, "When I get good and ready. It's outlawed. You can't collect a cent."

"It was outlawed two minutes ago," I replied, "but you renewed it when you admitted before two witnesses that the balance of the account was correct. I put that operation charge out for a trap and you stepped right in it. It will take you about twenty minutes to get to the bank and return. If the bill is not paid in exactly that time I will sue you and collect with costs." He paid. In other words, it is better to dun than to be done.

Once, while I was in St. Augustine, where Ponce de Leon found his Fountain of Youth and later died of it, a teacher in one of the public schools asked her class what they considered man's greatest accomplishment. Little Freddy said, "To earn a living for his family." Come to think of it, that little lad's clock struck twelve.

Many a young man has a first-born boy baby for whom he would not take a million dollars. Curiously enough, he probably would not give thirty cents for a dozen more just like him. Unfortunately, a number of these young men are members in good standing of the Society of the Double Cross and neglect to pay the doctor who ushered the aforesaid son into this world. If he does not pay at the time he doubtless never will. It is not like an accident case where a man may be caught wholly unprepared. Gently and with Christian resignation, he should be reminded that he has had nine months notice of the event and that he should be fully prepared to make some arrangement that will be satisfactory to the medical attendant, some arrangement that does not constitute a mutual disregard. It is just as well to get our fee as

to allow him to blow it, in due and ancient form, in a beautiful and picturesque jag. No man should be allowed to play the stork market on a 50 per cent margin, much less on no margin at all.

A fairly near and invariably a very *close* relative of that pustule, the chronic dead-beat, is the man who tries to beat you down on your bill which he is well able to pay. One such told me that my bill for removing his ruptured appendix was excessive. He admitted that I had saved his life and that there would have been much added expense had I sent him to the hospital, but contended that it was too much to pay for an hour's work. Being a man without guile, I remarked with an air of philosophical detachment, "Dan, I don't know how much your life was worth. You are the best judge of that — possibly — but try to see it from my standpoint. I spent as much time, used as much ether, exercised as much skill as if you had been a *real man*, and I can't see why you shouldn't pay me my customary fee." He mulled this over for a minute, while I grinned cheerfully, then he peeled his roll.

In dealing with the various types one must know his onions. He should learn to recognize the dead-beats on sight. They are omnipresent. Verily they do jostle each other, not only on the streets but in the country lanes likewise. I started out with the idea that it was my mission in life to heal the sick, that the matter of getting paid was a secondary consideration. I still believe it is secondary but not quite so much so. I followed this theory for twelve years, at the end of which I could not get a laborer to do a day's work for me. They all owed me. My time was being wasted in making long distance calls for trivial ailments and similar abominations. Since one did not have to pay the doctor, it was so much easier to have him come to dress Little Joe's cut finger than to lug the protesting youngster to the doctor's office. It was not only cheaper but it impressed the neighbors.

I notified the head of one household, a family that I had taken care of for years, without other compensation than a

few bushels of uneatable frost-bitten potatoes, that he must have the funds if he called me in the future. Shortly after this he called me, said he had the cash, and I went. I attended his wife but meanwhile he had mysteriously disappeared. Later I was taken to task by a clergyman for refusing to attend this man's wife when she had the grip. When I pointed out that the husband was well able to pay but would not, that I had served notice on him and must keep my word good even if *he* didn't, that the woman had two doctors in attendance and that she was not dangerously ill, he still insisted that it was hard on the woman when she could not have the doctor she wanted. I said, "It took twelve years to convince me that the policy you advocate is morally wrong. I could convince you but it would probably take twelve years, likewise, and I really haven't the time." He was apparently confuted but still unconvinced. When I asked him if he thought it quite proper for me to think more of this woman than her own husband did, he laughed and threw up his hands in surrender. No one gains much by argument. A flank attack is effective.

Where one cannot get a cash settlement, it is usually wise to secure a short-term promissory note. Such a note may be drawn "without interest." Such a phrase has a direct appeal to bargain-lovers and costs no more than to let the account remain on the ledger uncollected. Interest automatically accrues *from the time the note becomes due*. Notes are negotiable and have many advantages over a ledger account, not the least of which is that they are fairly good insurance against malpractice suits which are so frequently mere happy after-thoughts on the part of debtors.

Uncle Eph says, "That there Hawkins feller what married his first cousin an' lives up Cedar Hill way, is the wust kind of a dead-beat I ever see 'ceptin' his wife who is wusser than he is. I can't think of a single decent thing to say about *her*."

"You should try to cultivate a spirit of Christian charity," says Doctor Jenkins. "Now, I can think of something nice

to say about her right off the bat. No one can truthfully call her a durned son of a gun."

If a debtor who is able to pay refuses to sign a note acknowledging his indebtedness, I never hesitate to take legal action and when one of them comes into my office in a towering rage over being sued, with a sweet enjoyment of the situation I remind him of the time that I did this or that for him, and that he would not even acknowledge his obligation by writing his name. Assuming a righteous and inspired indignation I talk to him in language so plain that it is positively homely; I use words that will abide in his memory so long as the Nile runneth. It does him good and I feel much better. It is our Christian duty to teach some of these pests the principles of business morality.

Uncle Eph says, "Ole Doc Jenkins drove by here one mornin' last winter. He'd been up in the Settlement two days. He looked mighty tired and his mare was all ga'nted up. Bet you a veterinary would have trouble tellin' if she had cramp colic or the backache. Good fast horse too, not the kind that's fast when she's fastened to a post but the sort that's fast when she's unfastened.

" 'You expect to get anythin' out of them wops for stayin' two nights an' a day up there?' I asks him.

" 'Oh, I expect to get one hundred per cent,' says Doc.

" 'I hope you do,' I says, 'but I doubt it.'

" 'It don't cost any more to *expect* one hundred percent than it does to expect ten percent,' he says, an' slapped his horse with the lines an' drove off kind of grinnin' like. A little humor like that helps some of us to endure ourselves an' put up with each other comfortably. These fellers that take themselves too serious and are lim'ted to the fun of eatin' an' drinkin' an' sich like, must get all-fired tired of life sometimes.

"Say, are you the health officer? Why I ask is, one of our wust dead-beats came in here this morning an' wanted to get trusted fer a new tire so's he could go to a picnic. He was such

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a stinker I mebbe ought to have notified you that there was a nuisance right in front of my filling station. The best argument with that sort of a chap is a butcher's cleaver but I didn't have one right handy so I just told him, 'Pete, your excuse looks to me like this here cellophane that nowadays comes wrapped around nice five-cent cigars; kind of hard, durned thin, mighty cheap and perfectly transparent.' He gave me a nasty look and he drove off."

It may have been a chronic dead-beat who wrote from Sing Sing:

"I croaked a husky bar-keep onct,
I did and I ain't sorry.
I ast him for a bit of Scotch
And he sung *Annie Laurie*."

XXI

“DOMESTIC” NURSING

ONE of the serious difficulties encountered in the care of the sick in country practice, is the lack of adequate nursing. It seems to me, in looking back over a period of years, that in chronic cases, aside from malignancy and a few incurable affections of a degenerative nature, of which chronic nephritis would be a good example, I have lost more cases from unintelligent nursing than from any other recognized cause. Naturally I have no statistics to prove this. Such a mode of death is not listed among the International List of Causes of Death issued by our bureaus of statistics.

The white-enameled trained nurse is quite commonly not available when needed, is not considered necessary, or is perhaps beyond the means of the patient for a long-continued case. In her absence, the care of the invalid devolves upon the relatives who may have no aptitude or experience, upon friendly neighbors who take turns in looking after the ailing one (the patient being thus subjected to constant change), the average “handy” neighborhood woman whose knowledge may be utterly inadequate, or the “domestic” nurse who is far too frequently inefficient in many ways, owing to lack of systematic training.

Occasionally, we have to put up with some old crotch who, being incapacitated for more active work, takes up so-called nursing as an easy means of eking out a more or less honest living. Such attendants may be solicitous for the welfare of the patient, giving the medicine left by the doctor promptly on the stroke of the clock but, if they be not watched, forgetting to give food and water at proper intervals and in adequate quantities. It is difficult for them to realize that some

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of these essentials are of far greater importance, as a rule, than the remedies prescribed. Few horses ever win a race or take a blue ribbon if fed solely on condition powders. Nor is the so-called nurse wholly to blame in this. We are from babyhood far too frequently allowed to pick and choose what we shall eat and wherewithal we shall be clothed, to our own detriment. Sick people seldom have much desire for food and act accordingly. Left to their own preferences and inclinations, they are apt to curl up in a corner and die like sick dogs. They will take their pills, tablets, powders and potions commonly without objection, but will refuse food, proving thereby that the physician is, as a rule, a better disciplinarian than the average parent. The anxious friends are likely to humor the patient, while the domestic nurse frequently fails to realize that the patient's will power is weakened along with his physical strength and that a quiet insistence will usually be all that is needful in order to overcome the patient's objections.

The city resident who wished that he could live out in the country where he "could keep his own cow and have hens that would lay middling fresh eggs every day" has our entire sympathy. In the country, milk and eggs of the highest quality are always available, yet these are the very things to which, as a rule, the patients here object. Too much familiarity breeds contempt, and a prophet is not without honor save in his own country. I have a lot of other bromides available if desired. Anyhow, they "can't drink milk." The can't is really a won't. In the absence of complete stricture of the œsophagus anyone can drink milk. It seldom disagrees with anyone who is on a strict milk diet. It is tricky stuff in a way and will not stand mixing with chow-chow and sauer-kraut. Yet, with the addition of lime water or fluid magnesia, it is usually the best food available. Raw milk and equally raw eggs are two foods which contain practically all that is requisite for the maintenance of life indefinitely. Some of my patients ask me why cooked eggs are not as good as raw ones.

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My answer is the suggestion that they put a dozen boiled eggs under the old Dominick setting hen and await results. It saves a lengthy exposition of the value of vitamins. It is a sad commentary on human nature that we can see little good in things near at hand, that so many invalids should practically starve to death when the means available to avoid this are so abundant.

It is so easy to prepare appetizing and nutritious foods for the sick from materials at hand. A small bowl of chicken broth with a raw egg beaten up in it (taking care that the broth is not hot enough to curdle the egg) makes a rich and tempting-looking drink. I say chicken broth because chickens and eggs harmonize.

Or take oatmeal gruel made thin, with a milk base, sweetened slightly and salted. Given some mixed nuts from the grocery store and a nutmeg grater, the nutty flavor of the gruel can be changed from time to time and the pitfall of deadly monotony avoided.

If a patient finds some such food agreeable and evidently enjoys it, I have often found that the nurse would complain, "I fixed her some nice junket for dinner and she enjoyed it so but today it seemed to go against her." Why not, if it was offered as an exclusive diet.

✓ In the country, the doctor's visits are from necessity rather infrequent, and in some of these chronic cases, particularly in the later stages, the patient suffers with a dry mouth and throat and a fissured tongue, from lack of food and fluids. Instead of remedying this dryness by increasing the fluid intake, the well-meaning but misguided attendant fears that the patient will choke if swallowing is attempted; she, therefore, ties a bit of muslin rag on the end of a stick and swabs out the mouth of the patient from time to time whereupon the attending physician becomes violently profane. Not content with calling a spade a spade, he calls it an expletive old shovel, or words to that effect.

✓ An associate of mine in the hospital once informed me

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that when the Ten Commandments were promulgated, there were no physicians as a class, and that while these commandments were well suited for lay use, they were not adapted to the medical profession, were in fact archaic and certain modifications were necessary. With the utmost gravity, he informed me that, having descended from a long line of clergymen and his father being an eminent Doctor of Divinity, he considered himself well qualified to revise these in order to make them apply to our profession. I have forgotten the most of them (a not unusual thing with even the regular ten) but I recall two of them, one applying to the class of cases just under discussion, viz: "Thou shalt not swear save under stress of dire necessity." The other was, and I am sure no general practitioner will feel like taking issue with it, "Six days shalt thou labor and do all thy work and on the seventh likewise hustle to beat the band." He was not an irreverent man, but a very practical one.

Sick-room attendants who sit on the side of the bed, who tiptoe in and out of the room, who whisper instead of talking naturally and quietly, should be shown the error of their ways. The dumb one who asks the patient what she would like for dinner is looking for trouble. If she had judgment she would prepare some little dainty surprise that would tempt an appetite as wary and elusive as a brook trout.

I had an old lady with a pneumonia and a nephritis. I instructed her daughter to keep her on a strict milk diet but to give her as much milk as she would take and as often as she would take it. At each subsequent visit I inquired and was told that she was taking her milk all right. Meanwhile, the patient grew weaker and more listless. Finally I asked the daughter pointedly just how much milk she was taking at a time and exactly how often and was told that she had "taken a tablespoon night before last," explaining, when I protested, that she had not *asked* for any since that time. This was her interpretation of "as much as she would take and as often as she would take it." I saw to it that the old lady got a half

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pint of milk every two hours from then on and she rapidly improved. I noticed also an improvement in my method of giving instructions, dating likewise from that time. From then on I took no chances, any more than the Highland gillie who, at the end of a successful hunt in the snow-clad hills, was presented by the London sportsman with a fine fur cap, one with ear lappets, to replace his rather inadequate Tam O'Shanter. The succeeding deer season found him still wearing his old Tam and when the sportsman asked him why he did not wear the cap he had given him, the Highlander remarked mournfully, "I hae not worn it sin' the day o' the accedent."

"What accident?"

"Last Candlemas Day I was in Dumfries and my auld friend McGillicuddy says to me, 'McClennachan, will ye ha' a nipit o' drink?' an' *I never heerd him!*"

Some of these amateur nurses, given ample experience, do not do so badly. It is a pity, however, that they reach this stage much as Theodore Roosevelt said the United States entered the World War, by drifting in backwards.

There are all kinds of domestic nurses. Their name is legion. Sometimes we call them other names when we are exasperated. There is the overzealous one that anxiously inquires at half-minute intervals if the patient does not want her pillows shifted or the shades raised or lowered an inch. She keeps her patient in a state bordering on acute mania.

Sometimes similar results to that obtained by the fuss-cat are achieved by the N.C.A.G. through cumulative action. I once met this Neighborhood Committee of Ancient Gamblers when they were in executive session, having a quorum of six. I had been called in consultation to a five-week-old baby, the first child of a young mother of sixteen years' inexperience. Arriving shortly ahead of the attending physician, Dr. P. H. Dalphin, of Malone, I saw these six old women, sitting like crows on a fence, watching this baby who had a meningeal trouble. The child had a cold compress on the

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forehead, goosegrease on its nose, an onion poultice on its chest, pork drafts on its feet, and it smelled strongly of skunk's oil with which it had been liberally anointed. One of the committee changed the poultice, and I saw a brownish-looking cloth on the epigastrium. In answer to my inquiry, I was told that this was cinnamon tea. I made no comment, for two reasons; it was not my case, and I wasn't feeling quite fit. I merely sat and reflected that fortunately death was just as natural as life, and frequently kinder. The family doctor arrived, and took in the situation.

With a seraphic smile at the assembled multitude, which developed into a sardonic grin as it reached me, he said, "You know, I have often had some small baby for whom I could do but little, coming in for a daily visit, and some old neighbor body, with a wide experience in bringing up children, would take charge of the nursing, would feed and coddle the infant and bring it through when I was unable to do so, thereby earning my everlasting gratitude. But this baby is very small and weak, as well as seriously ill and with—ahem—six old ladies to fuss over it, *I don't really believe it will wear long enough to go 'round.*"

There is the melancholy one who wears her face in a sling, feeling that cheerfulness is inappropriate for the sick-room. She gives us all a cervicodynia. Likewise the timid soul who is mortally afraid to do this or that, lest something dire result therefrom. She is as suspicious as an old maid with her first date, afraid that she will be kissed and afraid she won't. She hasn't the nerve to do exactly as she is told so she splits the difference and resorts to half-way measures.

There is the self-sufficient one, supercharged with ego and "experience." She should be incorporated since she knows too much for any one individual. One such calmly informed me about a number of cases that were doing very badly indeed until she changed the entire plan of treatment (without informing the attending physician) whereupon they all promptly recovered. Later, she wondered why I never em-

ployed her. A few nurses of this kind will imperil our immortal or immoral souls by their audacious assumption.

Worst of all, perhaps, is the one who deliberately lies to you. I had an elderly woman who developed a serious bowel looseness attended with high fever. I ordered a full dose of castor oil. On my next visit, I made inquiry and was told that it had been retained and had acted very thoroughly a number of times. The patient grew rapidly worse, dying three days later. Just before she died, she had an enormous and exceedingly offensive movement. In righteous anger, I told this pseudo-nurse just what I thought of her and she admitted that the patient had coaxed her not to give the oil. She was the direct cause of this patient's death, and since then I have been on my guard. Like Si Perkins, one can often tell. He had a boy very ill with pneumonia and engaged a near-nurse to take care of him. When the attack was nearing the crisis, the nurse suddenly announced that she must go home at once to take care of her mother who had also come down with pneumonia. Silas investigated a little and came back, saying, "Evelyn, surely you are not going now and leave us in this whale of a fix?"

"But my mother is very ill and my first duty is to her," said Evelyn.

"That's all right, if she is really as sick as you say, but you promised to **stay as long as** we needed you and what I want to know is, **be you a-lying** to me or **be you not?**" asked Si.

"Why, what reason do you imagine I would have for lying to you about so serious a matter, Mr. Perkins?"

"Oh, none at all, Evelyn. None at all. Only you know you've got the same look on your face *I have when I lie.*"

Evelyn stayed.

"I think," said Mr. Dooley, "that if the Christyan Scientists had some science an' the doctors more Christyanity, it wuddn't make anny dif'rence which ye called in—if ye had a good nurse."

Fortunately, we have many of those warm-hearted, kind-

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ly, comforting and motherly, blessed old souls who have a natural "gift" for looking after the sick. They are endowed with an aptitude and an innate love for the work which is one of the essentials of a good nurse, trained or untrained.

It was a nurse of this kind who taught me the value of a lambskin tanned with the wool on. Such a skin placed under the lower sheet is infinitely better in almost every way than the rubber invalid cushion so universally used. The wool remains springy and does not mat down. It does not have to be inflated to just the proper degree. The rubber cushion as I find it used, is commonly blown up too much, giving a feeling of insecurity. Some enterprising manufacturer should place these lambskins on the market for this specific purpose.

Aside from cases where special knowledge of nursing is requisite, such nurses are a God-send to the communities in which they live. Their lack of training is offset by a well balanced simplicity and a Heaven-born wisdom coupled with common horse sense. If we had many more of this type we could keep them all busy, and if—Ho-hum! If a frog had wings, he wouldn't bump himself every time he lit.

Speaking of nurses reminds me of one time I was making the rounds with the chief surgeon of one of the large Montreal hospitals. There was a toothless, decrepit old man, some eighty years of age, in a private room. The chief said to him in his bluff, hearty manner,

"Old man, how are you coming on? All right I hope."

The old man croaked, "There's one thing I don't like about this place. I can't get used to dressin' and undressin' before a passel of young wimmen."

"Old man," said the chief, "if any of them should make improper proposals to you, just let me know and I'll take care of them."

XXII

BOMB-PROOF REFUGES

“WHEN in doubt, tell him it’s his liver and you can get away with it,” was the advice offered me by a prominent practitioner. Since getting away with it seems a praiseworthy achievement, I modestly venture to offer a few timely suggestions.

In this turgid age (*turgid* sounds nice, I think) it is no longer the part of wisdom to allow a patient to die of heart failure or, for that matter, of any of its variants such as cardiac insufficiency, paralysis of the heart, cardiac exhaustion, cardiac weakness or asthenia and others that, for the sake of brevity, I will not specify. They sound erudite and cultured—some of them at least—but I would strongly advise against their use. The callous and unfeeling lay press has, unfortunately, given these once useful terms altogether too much publicity of a derisive trend. It is now taboo in the best medical circles, or at least considered a little passé. It is still quite proper to say that a patient has (or, when unfortunately necessary, *had*) acute indigestion. Of late years this has taken the place, to a large extent at least, of the big blue ptomaine of the late ’80’s.

Acute indigestion shows signs of wear and tear and, on close inspection, you will notice that it is a bit shiny along the seams but it is still serviceable. It does not seriously impair its usefulness that the same line of edibles, upon which the patient has hitherto thrived, goes violently beserk and does him in with a solar plexus knockout. (Solar plexus — there is another one that might be useful in a pinch.) What matters it that a large percentage of acute indigestions eventually require an appendectomy, a cholecystectomy, or an

'ectomy for perforated gastric ulcer? *Cui bono?* which means, What the — or rather, Why bring that up? this being a more recent translation. An acute pancreatitis, an attack of angina pectoris or a coronary thrombosis, even a ruptured ectopic can be included under this nice phrase, acute indigestion.

Should any of the complications mentioned unfortunately ensue, a good explainer, if he but set his mind to it, can accomplish much. Dr. McConnel of Hoganburg once read me a lecture. "Macartney, you're not a smooth explainer. That's your chief fault as I see it. Let us assume, for instance, that eighty percent of our patients as we see them will recover with or without treatment. Men of extra skill, like you and me, let us say, will save five percent of those who would otherwise die, making our percentage of recoveries eighty-five percent. Others who have no sense will kill off five percent, reducing their recoveries to seventy-five percent. But if one of those blunderers is a good explainer, he can put it all over us. The discernment of the general public is nothing to brag about. They have no penchant for statistics but will accept an earful of smooth talk at its face value."

To resume, there is usually ample time to bridge the chasm and it is comforting to reflect that post-mortems in private families are comparatively infrequent, autopsy reports are not widely read, nor do they appear among our best sellers. We should worry.

Summer grip is a designation which deserves wider usage. The mere fact that grip is in the habit of coming like a hurricane, devastating an entire continent and almost as rapidly subsiding, is wholly aside from the question at issue. Plato, long before my time, pointed out that the opposites of things frequently look alike. Try that one on some of your critics. Summer grip may be epidemic or endemic, any dem thing. Likewise it can be indigenous, endogenous or any old dodge you prefer. A more highly refined phrase is intestinal influenza. It is more cultured and has displaced old-fashioned

summer-complaint, now deservedly, with other similar ailments, relegated to the innocuous desuetude of President Cleveland. Aberrant grip, now coming into vogue, is a highly intellectual term and may even save one the exertion of looking for evidences of acute tonsillitis.

For pains located elsewhere than in the abdomen at large, the term neuritis can be recommended. It is still untarnished, is in its prime, is not shopworn, shows no green around the edges, is stylish, hence it can be used with the same freedom, if not with the same despatch, as acute indigestion. It should come trippingly off the tongue and should be assiduously practised until one can say it in his sleep. It should be uttered in a rich orotund voice with Chesterfieldian urbanity and not, as Mr. Choate once suggested, with Westchesterfieldian suburbanity. This highly aristocratic designation has a wide range of adaptability. It has largely superseded the terms rheumatism and gout, being much more elegant. The older terms were all right in the age of the picket fence and the white house with shutters of a poisonous green, now happily vanished. Neuritis will cover a frontal sinusitis, an impacted wisdom tooth, a kidney calculus, a spinal cord lesion, a diaphragmatic pleurisy and a large number of other troubles, particularly those cases that we all meet with; those that never would have recovered if they had not, fortunately, taken in time whatever it was that we gave them. Also, and this is a mere afterthought, one can get a much larger fee (which is, of course, eminently desirable) for treating a neuritis rather than a plebeian rheumatism.

Some of our patients, unfortunately, seem to think that a neuritis which shifts from place to place is open to suspicion. Such an attitude is deplorable since we are not as yet prepared to admit that the three chief afflictions which jump around in the fashion alluded to, are neuralgia, rheumatism and fleas.

In communicable diseases, if there is any indication of a fatal termination, the adjective *black* is advisable. The

immediate outlook, if nothing else, will be black. It is not essential that black diphtheria, black measles or black smallpox be of the hemorrhagic variety. Why stick pig-headedly to what Monsieur Hicks calls the obsolete truth? Life is real, Life is earnest but why stress unpleasant things. It is more tactful to disregard them, particularly with those who are ailing, or their anxious relatives. For such, truth is hard, not readily assimilable and frequently utterly unfit. I neglected to put black pneumonia in its proper place along with black smallpox. This expression is doubly descriptive in that it may apply to those cyanotic cases which have been treated with the coal-tar derivatives.

Change of life and the menopause can ring the changes and give us pause as well. This will be a satisfactory diagnosis in any obscure trouble in the fair or fairer sex between the ages of thirty and ninety-six, after which senility may be cautiously substituted. There are no other limitations so far as my experience goes. Marasmus, malnutrition, growing pains and adolescence need merely to be mentioned, their adaptability being manifest. Essential hypertension and hypotension may be used either way like a ferry-boat. Essential hypertension is of two types, one where we have not been able to ascertain the cause and the other where it seems essential that some polished phrase be used. It is not really essential that you should carefully distinguish between the two varieties since either will prove satisfactory for some years to come. In fact, it can be used with the utmost nonchalance which means, as I take it, in an offhand and quite indifferent manner.

Poor circulation and creeping paralysis should receive due consideration and there is something peculiarly suggestive and appropriate about the latter. Spinal irritation was once in excellent standing but is no longer used by the *élite* owing to the dictates of fashion. Its twin sister, nervous prostration, was very useful in its day but is now showing the infirmities of age. It has already reached the century mark.

In my shy and timorous way I would modestly suggest that the term "trench mouth" is steadily growing in popularity; endocrine disturbance, like a large and but partially explored swamp, affords excellent coverage and refuge for a large variety of game, or games.

To those who have not given the matter earnest thought, teething seems appropriate from infancy to puberty. I hesitate to advise it unless great discretion is exercised in its use. While there are, in good sooth, certain privy counselors of the mighty who have given this their approval, there are others of equally high standing who maintain that teething is a perfectly natural process and incapable of originating pathological processes. There is a third or insurgent party which insists that an impacted lower wisdom may give rise to much real trouble. Until this matter is officially decided, it is perhaps better to avoid controversy by strictly limiting its usage. An analogous situation is presented when one considers the process of parturition which we must admit is, in the main, a perfectly natural procedure. Despite this, I have known quite a number of ladies who insisted that, during its progress, they felt very ill indeed. So the focus is slightly blurred.

The above list of cheap and convenient diagnostic labels is merely suggestive and is admittedly incomplete. I have merely endeavored, in my crude and halting way, to shed what feeble light I may on the general principles which should govern, without attempting to cover the entire field. As with Dr. Eliot's five-foot shelf of books, it should be capable of indefinite expansion, should need arise. Out of pure sympathy, this chapter is dedicated to the weak sisters of our profession with the suggestion that a short preliminary course of Hans Christian Andersen's classic work might prove of value, together with a study of the principles of protective coloration.

Since this chapter was written originally for the medical profession and is strictly confidential, only having gotten in

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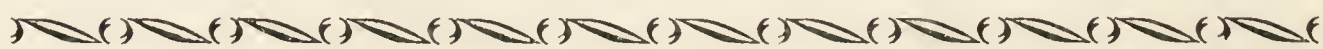
here through an inadvertence, I am rather in the position of the old colored woman who was praying on her husband's grave one Sunday afternoon.

“Cassius, ef’n you’s where I *hopes* you is, pray for me, intercede for me, ask forgibness for my sins, but, Cassius, ef’n you’s where I *’spects* you is, don’t you dare mention my name!”



XXIII

THE DOCTOR IN COURT



I FIND that the average doctor, if one can average doctors, has a wholly unwarranted dread of being subpoenaed as a witness in court cases. Personally, there are few things I enjoy more than having a pseudo-vacation of this nature, boarding at the best hotel available, having all my legitimate expenses paid, and a round fee as an expert witness added thereto. In return for this, I have but to spend a few hours a day listening to some interesting legal case and, on occasion, an hour or so of pure, unadulterated and possibly impish joy in matching my wits against some attorney whose knowledge of medicine and surgery should, in the nature of things, be much less than my own. Were I the defendant in a criminal prosecution, my views of the proceedings would naturally be from a less attractive angle, but so far I have escaped scot free. There are a few things which should be borne in mind by any physician who is called to the witness stand. So fortified, he has nothing to fear.

Disregard of a subpoena, legally served, may constitute contempt of court, subjecting him to reprimand and possible fine. It may also entail a liability to civil action for damages by the party in whose interest the subpoena was served. Given adequate reason, however, the physician is unlikely to be punished. For instance, if he is in actual attendance on a confinement, he cannot be compelled to leave the case to attend court.

In criminal cases, the physician may be compelled to testify to facts within his knowledge, like any ordinary witness, without compensation save such as may be subsequently allowed by the court, per diem, and mileage. A subpoena *duces*

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tecum is one requiring him to bring certain designated books, records or documents. As an ordinary witness, he is under no compulsion to testify to anything beyond the facts which he actually and personally saw or heard; to what actual knowledge he acquired through his five senses. Since this is seldom what is wanted from the medical witness, it being his *opinion* that is usually desired, he should be subpoenaed as an expert and his fee assured. To avoid argument, he should make sure of this before he is sworn.

When brought into court as an expert witness, he is in many of the States entitled by law to expert fees and cannot be compelled to give expert testimony without proper compensation. This on the ground that his opinions, his special knowledge and his deductions are his private property and are not properly subject, court or no court, to confiscation without adequate payment. This may be arranged with his counsel, but any such agreement will be void and uncollectible if such compensation be dependent upon the successful outcome of the case. The reason for this should be apparent even to the layman. Otherwise, such fees are usually collectible by law and, if no definite amount has been fixed, he may recover what is decided to be a fair and reasonable amount, in civil cases, from the party that subpoenaed him.

The legal fraternity fully understands that the time of a practicing physician should not be needlessly wasted, and it is customary for the medical witness, on being subpoenaed, to call up the attorney and make some arrangement with him whereby the attorney will notify him when he will be needed. In return for this the doctor will hold himself in readiness to respond promptly when so called. In this way, he will not be compelled to waste valuable time. It is simply a matter of courtesy between the two professions.

I was once called some distance as an expert in a murder trial. It was during a grip epidemic and I was over-run with work. By special agreement with the prosecuting attorney I was to be put on the witness stand at 10 A. M. At 4 P. M.

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I made contact with the attorney and asked him when he would put me on the stand. He said at ten the following morning. I explained to him that I could not possibly wait over until the next day but that I could come on the day following, that I had some very serious cases and could not be away from them two days in succession. He reminded me that I was under subpoena and that if I was not on hand he could send the sheriff after me. I suggested that he get out extradition papers for his sheriff, since I had some patients in Canada whom I must see and might be on the other side of the line. He threatened me with a fine for contempt of court. I said, "Before you do I want to tell you about a big skunk I met in the middle of the road one night. I was legally entitled to half the road, to the whole road in the case of skunks; as a physician, to the right of way over most vehicles; I could have run over him and killed him and still have been within the law as it was open season on skunks. I was on an urgent case and the moral right was in my favor but I waited until His Skunkship leisurely gave me the road."

He asked me what this had to do with the case in hand and I patiently explained that when the State Medical Society and the newspapers learned that I had stood for a fine of a hundred dollars and had preferred to look after my desperately sick people rather than dance attendance on an attorney who had broken his pledged word, said attorney would think he had run over a skunk and raised a whale of a stink. He waived his undoubted legal rights and put me on the witness stand without further delay.

The physician must ever bear in mind the distinction between ordinary and expert testimony, between fact and opinion. He may be required to give either or both, but he must not confuse them. In some respects, he has much greater latitude than the ordinary witness since it is usually his opinion which is desired, and he is at liberty to change his opinion at any time should additional testimony or evidence be brought forth warranting such a shift. Experts

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have been freely criticized because they do not always agree, but matters of opinion are ever a fruitful source of disagreement. Why should the public think it a reflection on the profession when the experts disagree? Remember that they are testifying to their opinions, not to the facts. The various members of that high tribunal, the Supreme Court of the United States, commonly disagree and no one thinks anything of it. The opinion of the majority makes the decision. There should be no disagreement as to facts, once they are established.

Once sworn as a witness, the physician must be constantly on his guard to distinguish carefully between what he knows and what he thinks he knows, to separate the wheat of his knowledge from the chaff of his belief, the sheep of fact from the goat of opinion, else some attorney, whose business it is to draw such distinctions, will get his goat. As an expert, his belief and his opinion may be of value but they must not be confused with the actual facts.

One day, just prior to a Presidential election, Uncle Eph said, "I don't know how this election is coming out. I don't think our candidate will be elected because I don't believe he will get enough electoral votes."

Dr. Jenkins said, "Why all this verbosity, Eph? If you had simply said that you didn't know, didn't think and didn't believe, your position would have been unassailable."

As an ordinary witness, we should confine our testimony to what we know. As an expert, what we think and what we believe is of major import. What we desire in the way of a verdict must receive no consideration whatever. A very human desire is to give testimony favorable to the side on which we are subpoenaed. This is a very dangerous pitfall and we should remember that we are under oath and scrupulously avoid any tendency to bias.

The witness should never be afraid to state that he is not sure or, flatly, that he does not know. Otherwise, he is looking for trouble. Many a woman, anxiously awaiting a

husband temporarily missing, might be even more unhappy if she knew where he was. Many a medical witness fears that saying he does not know may constitute a reflection on his knowledge and ability. This is far from being the case. He can say that he has an opinion or belief which is well-founded. If he volunteers an opinion, he will likely be reproved for so doing but he need not take this too much to heart. Neglect of the foregoing rules is a frequent source of the difficulties the expert encounters.

He will be frequently asked questions which cannot be answered intelligently because they are not properly framed. It is his undoubted right to insist that the question be so amended as to be capable of being properly answered. He will be asked questions which demand a categorical answer of yes or no. Not uncommonly such a question cannot be answered in this way without prejudicing the truth. If he gives a qualified answer instead of the simple yes or no, one or both attorneys are sure to object. If he persists, the judge (on the ground that his answer was not responsive) may peremptorily order him to answer yes or no. In such case it is up to the medical witness to hold his ground and, if pressed, to remind the court that he is sworn to tell not only the truth but the whole truth. He must make clear that, while under given conditions the answer might be yes, under other conditions it might be no; that as the question was framed, if it were answered in either way it would not be the whole truth. For this reason, he cannot answer it truthfully, by either yes or no, without qualifying his answer and that he cannot be forced to tell even a partial untruth. Such a position is impregnable and will command the full respect of the court.

For time-worn example, suppose the cross-examiner asks you, "Have you stopped beating your wife?" Will you answer it by either yes or no? If the cross-examiner gets sweet, gentle and polite, watch your step and be on guard. He is going to hit you. He may ask, "Have you the brains of an ass or haven't you?" You are in a hole if you answer it either

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way, or if you split the difference, if any. Naturally they are not likely to ask you these questions but others equally trying.

When the physician is testifying as an expert, he may with propriety be asked to withdraw at times when other experts may be on the stand and should do so with good grace if so requested. The question of whether a witness is qualified to give expert testimony or not, is largely left to the discretion of the court. Not infrequently, on cross-examination, the opposing counsel will badger and bait the witness, endeavoring to get him confused and embarrassed. Here it is essential that the witness remain calm and unruffled, remembering that it is part of the game. If he but holds himself in hand, the magistrate, the jury and the spectators will be on his side. They realize, subconsciously perhaps, that the lawyer is here on familiar ground while the witness is not. When a dog is worrying a kitten, the sympathy of the crowd is always with the kitten. If she has sufficient nerve to stand her ground and take an occasional swipe at the dog's nose, they are all hugely delighted.

Even the feeblest joke at the expense of a badgering cross-examiner, the simplest come-back (if accompanied by a smile) breaking the monotony of the courtroom, is so unexpected that it will bring a gale of laughter. You may rest assured that the attorney will drop that line of endeavor as if it were a hot coal, never to resume it, with you at least.

The opposing counsel once asked Joseph Collins, "Then you are a neurologist pure and simple?"

The doctor's answer was, "Moderately pure and always simple." The laugh saved him from further badgering.

One attorney, when I testified to the good character of a lady, intimated that I knew almost too much about her. Outside of the courtroom I would have knocked him down. I held my temper, smiled and suggested that one could usually tell a good egg from a bad one without breaking the shell. He made nothing by that question.

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Occasionally an attorney of another type, or I might say stripe, will attempt to belittle and humiliate the doctor on the stand. He may cast reflections upon his knowledge, his qualifications, his experience, or what have you, in an unworthy and insulting manner. It is to the credit of the legal profession that this is seldom resorted to. In such a case, I have found it best to ignore the attorney, to turn to the judge and ask His Honor if it is the custom of his court to allow attorneys appearing before him, to treat reputable witnesses in such a discourteous and ungentlemanly fashion. The offending attorney will usually come in for a sharp reprimand. On the other hand rest assured that if you will stand for such treatment, you will occasionally get a lot of it. First, last, and all the time, hold your temper. Whom the gods would destroy they first make mad. An old saw, but one frequently made use of in the court room. On the witness stand remember that you must look both ways on a two-way street and that it is necessary to be a straight shooter if you would hit the mark.

Nearly two thousand years ago Quintilian, Dean of Roman Law, said that a timid witness may be frightened, a foolish one misled, an irritable one made angry, a vain one flattered, a prolix one led to side issues, a sensible one rendered harmless by ridicule or made to appear bigoted and obstinate. A trained cross-examiner in these modern days will still play skilfully on all these keys. Remember to take cavil whence it comes.

The physician cannot ordinarily be forced to give information communicated to him in confidence while acting in his professional capacity. The witness need not concern himself with the finer points and legal variation of this in the several states as all such will be decided by the court.

Questions of court procedure, admissibility of evidence, relevancy and competence of evidence and kindred subjects need not be considered here, being determined by the court. The *opinion* of a witness is incompetent unless he is giving

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testimony as a qualified expert. In a general way it may be stated that no substitutional evidence is admissible so long as the original evidence is obtainable. Standard medical works are, in general, inadmissible. As evidence they are ruled out almost invariably if the author is still living. This for the reason that the author himself would furnish better evidence, *i e.*, he could be sworn and cross-examined. The ephemeral character of accepted views, the conflict of authorities, and the likelihood of confusing the jury by technical terms, are other and obvious reasons for this ruling. Remember that you are not before Jehovah's awful throne when you are in court. It is better to know a little more than you say than to say a little more than you know.

Many malpractice suits remind me of the lady who sued the gentleman for damages to her King Charles spaniel because the dog broke two teeth when he bit the man on his leg. Most malpractice suits are a sort of aftergrowth, springing up only when the doctor's bill is presented for payment.

The only time I was ever threatened with a malpractice suit was some thirty-five years ago when I was sent for to treat an old Civil War pensioner for a neglected case of blood poisoning. I opened and drained numerous pus collections, running a rubber drain through the mid-arm and, later, amputated his thumb which was entirely dead and gangrenous at my first visit. Save for the loss of his thumb, which was inevitable, he made an excellent recovery. A year or so later he entered my office and stated that he had been before the Board of Pension Examiners at Ogdensburg and the physician who examined him had told him that it was a bad job to remove a man's thumb: that he should sue me for three thousand dollars damages. "But," I protested, "the thumb was gone when I first saw you." After some argument and discussion in which I found I was making no impression, I asked him if he had engaged a lawyer and finding that he had failed to do so, asked him who he thought was the best lawyer in town. He named M.C. Ransom.

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“Do you know where his office is?” He shook his head.

“Would you like him to take up your claim?” He nodded.

I took him out to the street, pointed out the location of the attorney’s office and said, “No use to make any trouble over this, John. Just run up to his office and ask him to make out your claim in proper form and then come back and collect it from me. I usually carry six or eight thousand in my trousers pocket for just such emergencies.”

I smiled, patted him on the shoulder and gave him a gentle push toward the lawyer’s office. He looked me in the eye for a moment, then crossed the street and went in the opposite direction. In about an hour he staggered back thoroughly soused, got into his buggy and drove home. That is all I ever heard about the malpractice suit.

Uncle Eph remarked one day, “Seems to me, every time I listen to a lawsuit, that the jedge is sort of hog-tied by too many laws and by what some other jedge decided ’way back in the Sixties. They *want* to do jestice but sometimes they can’t. The assemblyman was in here one day gettin’ gas an’ he asked me if there was anythin’ he could do for me down at the Capitol. I told him I would admire to have him put through a bill abolishin’ every law on the statute books, substitutin’ the Ten Commandments an’ givin’ the jedges a free hand, an’ try it for three years an’ see how it would work out. Mebbe it wouldn’t work an’ mebbe it would; anyhow, it would give the jedges more elbow room.”

XXIV

DIET

OF THE making of many books there is no end, and after reading books on dietetics, I am profoundly impressed with the knowledge of my own limitations. I have an acute attack of inferiority complex, compound and comminuted. I once had some pet prejudices, in the way of foods, to which I clung. Now, save for some minor facts and fallacies regarding calories and carbohydrates in diabetes, some acid-alkaline-ashes in acidity (alliterative in their sound and vitamin contents if nothing else), I am all at sea, lost, strayed, stolen, mayhap *versunken*, or mebbe *spurlos versenkt*. I have arrived at the point where I am confident that I do not know a single thing about dietetics, for certain, I mean. I could have reached much the same destination and saved much mental wear and tear if I had simply rested and calmly awaited the development of senile dementia.

Early studies in chemistry gave me the impression that red and white meats were practically identical in composition, that poultry and game were merely variants, that fish was not dissimilar. Evidently I am wrong. According to eminent authorities, red meats are highly injurious to whatever you happen to have at the time, and white meats equally destructive to whatever disease you are going to have next. We are credibly informed that sole is the sole fish allowable in certain disorders, while flounders are — well, this sort of thing sets me to floundering, all right. I try to remember which is which, and if I should or shouldn't, but unfortunately I have a poor memory in some respects. I get mixed and give exactly the wrong thing. Now, I can still remember some things all right. Not mere isolated facts like those just

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cited, but things that have a reason back of 'em. That's the memory system I've followed. It may be all wrong, but I'm rather attached to it. I wish that the next writer on diet would please, *please* give me a reason or an explanation so I can associate my ideas, as it were. There must be some reason; they seem to expect us to take their instructions seriously, not with a tongue in the cheek. Else how can they be so positive, but why keep the reason such a profound secret? That question of red versus white meat has always puzzled me. It may be that gentlemen prefer blondes. But no, that cannot be the reason, for I recall that gentlemen, and some who, I suspect, are not gentlemen, seem to prefer the dark meat, while the ladies, God bless 'em, almost invariably choose the white.

But hold! Is it, might it be, could it be possible, that, as with religion, our convictions are largely the result of early impressions, of environment and habit, of personal preferences and individual idiosyncrasies? If we all saw things alike, how woefully monotonous this life would be! Maybe the other fellow has a right to his opinion, even in dietetics. Just so long as he does not confuse opinion with fact, personal preferences with therapeutic principles, and does not forcibly thrust upon us those things which appeal to his own appetite. It seems to me that some time or other, long ago I think, I read somewhere or heard it intimated in some way, that man's dental equipment indicated that he belonged to the order of omnivorae, like a pig, as it were, also that one's appetite had some useful purpose and could be trusted, within limits, of course.

Speaking of pigs, a man came into my office a while ago, and, in response to my inquiry, said he had been complaining of his stomach. After taking an inventory of all he had put into it during the previous week, it seemed to me that his stomach had just cause to complain of him.

One of the best rules for obesity is to cultivate the gentle art of doing without and, in particular, doing without fats.

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At any rate, in my own case, I have managed so far to keep my weight within normal limits by this means, together with plenty of exercise. One of the best exercises for obesity is to push one's self back from the table three times a day. It is a fast way of reducing, though fasting is easier to preach than to practice. It has the virtue of being economical.

Speaking of fasting and of economy, an old hayseed rutabaga doctor living in the hinterland, twelve miles back of beyond, gets up a fairly robust appetite. We are reputed to have but two seasons here, Winter and the Fourth of July. After a long ride and a little gentle exercise shoveling out snowdrifts and lifting his friend Lizzie back on the road, he finds that textbooks on diet lack nutriment though full of calories. He is in a mood where he prefers victuals to vitamins, so to speak. Most any old thing tastes good. He has become dinner-conscious, and the anticipated comfortable feeling of repletion, aided by a good magazine and an excellent cigar has certain attractions. A help-meet skilled in the use of a can-opener is justly appreciated. He seems immune to tin-poisoning and so far ptomaines and botulism have stayed their hands. He is a simple, gentle, trustful soul with faith in the established order of things, three good square meals a day, for instance.

Of course, his wife never knows when he will come in for his meals or when he will get to bed at night or when he must cancel social engagements, but, if she is the right sort, and she usually is, what a heavenly angel of mercy she can be to him! Perhaps he is too utterly tired to tell her that but he knows. I haven't mentioned any names so I am now privileged to go back to the first person singular.

I have even known a number of people who, in the absence of duodenal ulcer and a few things like excessive blood sugar, with reasonable digestive powers, some discretion as to quality and quantity, together with thorough mastication, have gotten away with a large variety of proteins, carbohydrates, hydrocarbons and plain food without experiencing

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any really evil results. I have in mind one patient who not only did this but topped each meal off with a liberal noggin of Holland gin. He had drawn a few sober breaths in his school days, but definitely abandoned that idea from then on. He survived three attacks of pneumonia in his eighties and died at the age of ninety-six. Of course, every rule has its exception, except this one rule. You can argue it either way without getting anywhere, so I give it up. I never was good at conundrums.

I read in a medical journal the other day, so it must be true, about a man who ate an egg and it nearly finished him on account of his protein sensitiveness or sensitive proteinness, I forget which. Considering the millions that are eaten in this country every year, all I can say is he appeared to be out of luck. Our eminent statistician, Mr. Abou Ben Add'em, of whom you have doubtless heard, has figured out that if all the eggs laid in this one country alone, since the Declaration of Independence, were again laid, this time end to end, they would present the appearance of the hoopsnake, no end to them!

Now this man that ate the bad egg, or at least the egg that was a bad actor, must have felt like my old friend, Prentice Smith. He was asked one day if he was married and, after a little hesitation, admitted the soft impeachment. When asked if his wife was living, he rather side-stepped it a little. "Well, some on 'em died and some on 'em ran away, so I thought I wouldn't try it no more." Doubtless this egg-protein reactor will not try it any more without at least wringing the neck of the blamed thing first. Otherwise, he is just naturally bound to ruin himself.

We had a near neighbor, Mrs. Jerry Sullivan, who used to drop in of a mornin' to see us and to tell us of the good breakfast she had made for her husband before he left for his day's work. She would say with the utmost unction, "Sure it's me that puts the feed to me Jerry!" adding, "'Tis the shape of an egg I am meself with it all."

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It will be a piosity which, we might explain, is an extremely pious act, if the next writer on dietetics will just give us his reasons why, if any, couched in simple language, not too technical you know, in words suited to our mental calibre, which we admit is nothing to brag about; we will promise to be good and carefully follow out his directions. Meanwhile, though it may be dangerous to eat this thing and that under this condition or that, as no doubt it is and then some, and far be it from me to dispute this until I hear definitely all about it, I must still go on in my ignorant way, feeling that it may be still more dangerous to go without food altogether.

The above sentence seems a little involved, but it is now very late and I am not going to re-write the thing. Besides, I want to read over the article by Vilhjalmur Steffanson telling how well he kept for months and years on an exclusive meat diet.

Doubtless some foods at times have killed certain people but those who have passed on have been very reticent with me as to the exact manner of their demise. First-hand facts being therefore not available, I am at the mercy of the somewhat choppy sea of conflicting opinion.

Uncle Eph says, "I was up to Old Man Cushman's t' other day an' we had a big dinner. Them Cushman's are all sure big feeders. Johnny, the little grandson, ate a whale of a dinner an' after we was all out on the front stoop smokin', I see through the winder the little tyke breakin' a lot of home-made bread into a quart bowl of fat pork gravy an' ladlin' it down with a tablespoon. Jest then his ma came in and says, 'Why Johnny, you're goin' to make yourself sick eatin' that fat gravy,' an' he jest looks up an' grins an' says, 'Maw, Maw. *I likes vittles.*' Them Cushmans are alluz as hungry as tapeworms.

Sile Perkins' folks are different. The Minister was there one afternoon and it was gettin' late and he says, 'I guess

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I better go home; it's getting near suppertime. What time do you folks have supper?'

"Mrs. Perkins didn't open her trap but Si, the dumb fool, says, 'Jest after the company leaves, gen'ally.' According to that, what Aunt Mirandy says can't be so. She says the Perkins have dried apples for breakfast, water for dinner and jest let 'em swell for supper." According to Dr. Dooley, such a diet could not be called "A, Number 1, Double X, ***Hennessy."

To those of us who have merely reached our anecdotage and not our dotage, it would seem that there is, of late years, a decided change for the better. When I read about cardiac, nephritic, diabetic, high and low calorie, high and low protein, salt-free and other diets, I do not drop to sleep in my desk chair and inadvertently drop my book into the wastebasket as of yore. In fact, I find some literature on the subject of diet very interesting and I trust that my previous comments will not be taken too literally. Allergy is always with us.

A few years ago I was driving along a road near St. Augustine and someone in the car inquired how a certain Spanish name was pronounced. I said, "I do not know. Proper names, spelled in the same way, are not uncommonly given a different pronunciation in different localities, such as Beaufort, N. C., and Beaufort, S. C., or Gouverneur Street, in New York City and the town of Gouverneur upstate. In England it is even worse; take Beauchamp, for instance, which' is pronounced Jones."

"But Doctor, it is pronounced Beecham," came the protest from a New England school teacher in the back seat. Gratefully and somewhat gleefully I took to heart this pearl of wisdom. I was having an attack of what some of our old ladies call "inward spasms."

Speaking of eats reminds me of a Mr. and Mrs. Will, nice old folks of Scotch lineage. They didn't drink, smoke, play pinochle or indulge in any such depravity. One evening

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late in March Mr. Will brought up from the cellar some "winter" apples slightly wrinkled after their long storage. Presently he passed them again to his cousin: "Have another apple, Alex."

"Was that an apple I just ate?" inquired Alex. "Gee, I thought it was a cork."

XXV

PRESCRIPTIONS

WITH the advent of the ready-made pill and tablet, the art of prescription writing has, to a large extent, fallen from its high estate. It is a convenience to call for a hundred Blaud's pills or Dr. Wheezem's asthma tablets and let it go at that. It is handy, but is it art? Wheezem's tablets are likely to contain belladonna and if the patient happens to be abnormally sensitive to belladonna, it is difficult to make adjustments. It is convenient to order a pint of Comp. Syr. Hypophosphites, Fellows', as a tonic and a bottle of Hinkle's tablets to be used as needed for constipation, overlooking the fact that each contains quite a respectable dose of strychnia. Occasionally we have known of cases of strychnia poisoning resulting from such unintentional doubling of the dose. Not many, it is true, but with a drug like strychnia, *one* case would be too many. As for Blaud's pills, a large percentage of those found in the pharmacies are utterly worthless, being dry, hard, and insoluble.

I had an elderly woman with a most obstinate fecal impaction. I was not aware of it at the time, but her son had sent her a bottle containing 500 foil-coated Blaud's pills of French manufacture. She had taken these for months and the bottle was about empty. When I at length succeeded in clearing the impaction, I found it composed almost entirely of Blaud's pills with the foil coating practically intact.

I was treating a young woman with secondary anaemia and prescribed Blaud's pills made by a pharmaceutical firm with a well-deserved reputation for making reliable and high-grade products. Repeated blood-tests showed no material improvement. One evening, while I was present, she vom-

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ited and, in the vomitus, I found a lovely pink sugar-coated pill which she had taken after supper, a pill with a white slip of undercoating which she had taken after the midday meal, and a stark-naked brunette pill which she had swallowed at breakfast time, all as hard as buckshot. I changed makers on that particular pill and began to get results. My faith in Bland's pills was restored. There are pills of the friable type which are quite soluble and others of the soft mass type which are entirely satisfactory. I found one make that appears to remain soft and soluble for an indefinite period under all conditions of storage. There are doubtless other makes that are equally good but I have made no further experiments.

Quinine pills are notoriously insoluble, the capsules being far preferable. Occasionally even these are ineffective and we must resort to a solution made by the addition of an acid, or to its intravenous use. To anyone born in a drugstore and fattened on tablets, this being nearly my case, such things seem obvious but it is not necessarily so to others.

Some patients are very sensitive to certain drugs, have idiosyncrasies. Belladonna, for example, can be taken by some only in minute doses. I had one patient who developed the characteristic symptoms of belladonna poisoning to a marked degree when I dropped some standard atropine solution in her eye to dilate the pupil for examination of the fundus. Children, as a rule, tolerate belladonna in large doses. They are rather intolerant of the opiates. On the other hand, there is a marked tolerance for opium in threatened gangrene, in surgical shock, in peritonitis. Eclamptic cases will stand large doses of veratrum viridis.

Some patients, if given opium or morphine, will vomit constantly. If morphine and hyoscine are given subcutaneously, the combination is commonly well borne in these cases. If the morphia is given by the mouth in minute doses at short intervals until it takes effect and then is tapered off slowly, it seldom causes nausea. A quarter grain of morphia,

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placed *under* the tongue, will be absorbed almost as rapidly as if given by the hypodermic method.

The so-called cumulative action of drugs is largely an absurdity. It occurs in the administration of remedies which are either absorbed with difficulty, are eliminated slowly, or in those which have a slow but persistent action. It seems to me utterly illogical to give digitalis and nitroglycerin, for example, in the same mixture or pill. The action of nitroglycerin is nearly instantaneous and quite evanescent. It is difficult to get the full effect of digitalis within forty-eight hours if given orally. If the mixture is given with sufficient frequency to maintain the glonoin effect, it is more than likely that the digitalis doses will overlap and give rise to its "cumulative" action, so-called. The one is a high RPM motor and the other a slow, heavy duty engine. They cannot be made to match up well, for they do not synchronize.

The alkaloids resemble the alkalis in that they form definite chemical compounds with the acids. Physiologically there is no resemblance. The action of sulphate of morphia, muriate of morphia, other morphia salts is always that of the alkaloidal base, morphia. The acid radical is of slight importance. The reverse is true with the alkalies proper since, here, the acid radical is the dominant one. Potassium iodide, sodium iodide and other iodide salts are similar in their action. Bromide of potassium differs in no great degree from the corresponding salts of sodium and ammonium. The molecular arrangement varies. One may contain a relatively larger proportion of bromine than the other and the base itself may have some influence if taken continuously for a long period, but in the main the law holds true. Many synthetic remedies follow a somewhat similar rule but here the acid radical is likely to be the dominant one. The therapeutic dilettante, who prescribes the phosphate or the succinate of some potent alkaloid, save as this may be advisable by reason of its greater solubility or some similar factor, is merely a hair-splitting piffle-hound. For the benefit of those who have not had a

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liberal education in the American language, I may say that this means that his attitude is one of academic absurdity.

The vegetable juices and acid salts, such as citric, malic and tartaric, are potentially alkaline. When burned up in the system or otherwise decomposed, the resulting ash is alkaline in action and this neutralizes acidity. To prohibit the use of lemons, oranges, grapefruit, on the ground that the body fluids are too acid, is an acknowledgment that one is ignorant of the principles of elementary chemistry.

Many remedies have a secondary action which is directly opposed to their primary effect. A dose of castor oil will purge, but the cathartic action is followed by a tendency to constipation. The freedom from hemorrhage in tonsillectomies done under novocaine and adrenalin carries with it the liability to hemorrhage when the primary action of the adrenalin passes.

Polypharmacy should be avoided. The rifle is a far better weapon than the blunderbuss. Shotgun prescriptions *may* be justifiable at times. Uncle Eph says, "Si Perkins can't hit a barn from the inside even with a double-barreled shotgun. Come to think of it he might, though, if the old gun happened to be cross-eyed."

Eph says, "When a heavy barn door needs swinging to in a high wind, don't kick it; take it slow but push it stedly." The same principle applies to the administration of many remedial agents.

We have just completed reading the leading article in a current medical journal, after which we have an impression that, with the files of the Archiv. f. exper. Pharmakol u. Inn. Med., a modern medical dictionary of the first water, a book of synonyms, a thesaurus, plenty of paper and a fresh typewriter ribbon, we could expand the above idea indefinitely, but we have already suffered several attacks of the pip and we hesitate to run further risk.

Joe Lapage, a French-Canadian habitant, was in recently to get a prescription refilled. When he was asked if he was

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feeling any better, he said. "I t'nk me, dose medicine was do me lots of good but, *Mon Dieu*, it has an awful clumsy taste."

We read a lot about the evils of substitution. Any reputable pharmacist can be depended upon not to substitute. There are unscrupulous men in every profession and pharmacy is no exception. Substitution is no new evil. It dates back much further than the historic incident in connection with the daughters of Lot.

The old darky said to his wife, "Look hyah, Chloe, that ain't moonshine nor neither white mule in that bottle. That's Pluto watah. You sholy ain't gwine to drink that, is yo?"

"I ain't goin' to do anythin' else but."

"Yes, you is, woman, ef'n you drink that you sholy is."

On the whole, a little practical knowledge of pharmacy does not come amiss. I may add this item for the benefit of the doctors. If you order solutions of homatropine, eserine, nitrate of silver or other expensive drugs for your office stock, they usually deteriorate very rapidly, especially cocaine. If you order them dissolved in salicylic acid water, $\frac{1}{4}$ gr. to the ounce, they keep indefinitely and the silver solution will remain colorless. Since I followed this method I have had no trouble or at least darned seldom, as Gilbert says. Once I dropped a bottle of nitrate of silver in the sink and it broke. I had about ten cents worth of trouble. The bottle was nearly empty at the time.

XXVI

REMEDIAL AGENTS

THE reader who has no interest in the basic laws which govern to a large extent the administration or use of remedial agents is advised to skip this section.

In order to avoid redundancy and needless repetition, remedial agents will be classified briefly here. They are of two broad classes, *medicinal* and *non-medicinal*. Medicinal agents enter the system in solution, as a rule, by the stomach, the rectum, the skin, the lungs, the subcutaneous tissue, or by the intravenous route. Non-medicinal agents are various therapeutical measures acting otherwise, for example: heat, cold, electricity, radium emanations, light therapy, climate, change of environment, hypnotism, massage, the action of germicides, etc., a wide field of exceedingly divergent agents. The term is merely one of convenience.

Likewise for convenience and to promote clarity of thought, medicinal agents may be divided into two broad classes, disease medicines and symptom medicines. The former act upon the constitution. A further subdivision is necessary. Constitutional, or disease medicines are in the main of two kinds, restoratives and alteratives. Restoratives are, as the name implies, those remedies which are natural to the system, which act as foods or supply deficiencies, for example: iron, the calcium salts, the phosphates, iodine, cod liver oil, the vitamins. Alteratives are those not natural to the system but which produce permanent changes in it, such remedies as mercury and arsenic. Both of these classes act slowly but their action, in the main, is permanent and curative.

Symptom medicines, functional remedial agents, act

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promptly; their full effect may be secured by a single dose if it is adequate, produce temporary effects, result in no constitutional change, are not curative in the sense that iron is in anaemia or iodine in goiter. Morphia, strychnia, aconite, emetics, cathartics and diuretics are illustrations. Symptom medicines in overdose may result in poisoning but, if the patient recovers from their poisonous action, leave no permanent effects as a rule. Contrast this with the evil effects of calomel when it produces salivation. Again, calomel may not act merely as a constitutional remedy but as a functional one as well since, given in sufficient dosage, it acts as a cathartic.

These rules are subject to variations but they nevertheless serve a useful purpose provided we bear in mind that all easy generalizations are not fully trustworthy and may be dangerous. Irvin Cobb says, "It's like all generalities. It's likely to be right in the main and wrong in spots."

In a preceding paragraph it was stated that symptom medicines are capable of producing their full effect from a single adequate dose. This is frequently true, but the dose must be adequate. If you have a barrel weighing two hundred pounds and you wish to lift it to a platform, you may lift a hundred pounds a hundred times without effect, but if you lift two hundred and ten pounds on it just once, you get immediate results.

Of recent years light-therapy, radiation in its various forms, electro-therapy, endocrinology and organo-therapy, chemotherapy, all these and others, have come to the front. The violet ray, the X-Ray, radium, diathermy, thyroid and hepatic extracts, adrenalin, pituitrin and insulin, the various hormones, vaccines, toxins and antitoxins, intravenous medication, novocaine and similar agents, the long line of synthetic compounds in common use, the vitamins and improved food products and a host of other remedial agents are now indispensable. No efficient substitutes have as yet been found for the opium derivatives, digitalis and a long line of drugs and pharmaceuticals. It is safe to say that the pharmacist will

still be with us for a long time to come. Times change, methods undergo modifications but the basic laws of nature remain. The newer remedial agents will augment, rather than supplant, the weapons with which we are waging the fight.

We are accustomed to speak of tonics in a rather loose way, the general idea being that anything which "tones up the system" is a tonic. I sometimes think that the word restorative might well be substituted. Not that I object to the word tonic, it is expressive and that is the primary function of language in general — when it is not used as a smoke-screen for the purpose of concealing our thoughts. Tonics, however, when one attempts to arrange and classify them, when they are boiled down and sugared off, as it were, seem to fall into one general genus, *i.e.*, *foods or those agents which are generally related to foods*. At least, they so arrange themselves in my mind. They form several distinct groups of families further subdivided into various species and sub-species.

First, we have the foods proper, fresh air, three square meals a day, agents like cod-liver oil, the vitamins, iron, certain organic extracts which supply deficiencies, etc. These are not medicines in the ordinary sense of the term.

Second, those that promote the digestion and assimilation of food, of which pepsin, hydrochloric acid, pancreatine, some of the enzymes, diastase, insulin, etc., are examples.

Third, those agents which stimulate the digestive functions, increasing the desire for food, gentian, columbo, quassia and the like.

There is a fourth, or waste-basket class, which includes many remedial agents which are called tonics, such as strychnia or phosphide of zinc. Both of these are considered nerve tonics. Our knowledge of many of these is still quite vague, so far as their exact mode of action is concerned. It is still a question if the action of strychnia, aside from its use as a bitter, like nux vomica, is that of a true tonic, or if it is

merely a nerve stimulant. The essential fact remains that all the undisputed tonics are, more or less directly, chiefly nutrient in their action. With this held in mind, the indications for the use of these agents become much clearer. ✓

✓ Since the earliest time when any effort was made to place medicine upon a scientific basis, various attempts have been made to formulate some rule for estimating the dosage in children. The adult dose of any remedy, after it has been experimentally ascertained, becomes established, and varies only within certain limits. The dose of any ordinary drug suitable for a vigorous adult is in the very nature of things, obviously too large for a child or an infant. Since the growth and development of the child is a continuous process, varying from day to day, from year to year, some sort of a slide-rule whereby the approximate dose for a child of a given age or period of development could be ascertained, was obviously necessary.

✓ Young's rule, made public in 1823, is the one which received practically universal acceptance. This rule became standardized, largely owing to its simplicity and ease of application as compared with the table of Gaubius, the Guy's Hospital table, or the still more elaborate one of Hufeland, also published in the early part of the last century. Shaller's rule and that of Cowling are mere variants of Young's.

The rules of Young, Cowling and Shaller's adaptation of the same, are all open to one fatal objection from the very start; they begin with a child one year of age and make no provision for infants of lesser age. The fault is with the mathematical principle involved. Any sliding scale based upon the age of the patient would be open to the same objection. The method is wrong in its conception; wrong in principle, and wrong in beginning the mathematical calculation with a child one year old. Infants are still reasonably prevalent.

Here they stop, and can go no further. Mathematically, a child one year old is 365 times as old as a child one day old. Regardless of this, shall we, as these rules seem to imply,

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give this day-old infant the same dose suited to one 365 times his age, or shall we give him one 365th, and on leap year one 366th of the dose referred to? This, of course, is a *reductio ad absurdum*; but is nevertheless, a logical sequence of a faulty rule.

To illustrate still further the utter absurdity and inadequacy of rules based upon the age, let us suppose that a doctor is called to a maternity case, and after tying the cord, finds the babe, born a minute before, requires a stimulant or other medication at once. Compute the dose for him according to any mathematical formula based upon age and remember he is only one sixtieth of an *hour* old. (Please be quick about it, too, for his age has actually doubled while you are thoughtfully scratching your scalp over the center of mathematics.) Surely the result would please our Homeopathic brethren. Whose rule will we follow in estimating a dose suitable for this child one-half millionth of a year old? Anyone who escapes imbecility by even a narrow margin can see the absurdity of this. The present methods of computing dosage in children are as antique as dinosaur eggs, fine museum specimens but utterly useless otherwise.

In my judgment, any calculation based on the age is fundamentally wrong in principle. After over a century of trial, they are practically unmodified. It is not necessarily the right road because it is well traveled. They might serve if the dosage as estimated in these various ways agreed in the main. In this connection, a comparison of the doses for the various ages, worked out under these separate rules, is of interest.

I made a careful computation of the dose obtained, in the case of a child one year old, by following out each of these rules and tables and found that the results differed by 325 percent. Since no provision is made for lesser ages in most of these, the comparison must perforce end here, but the discrepancy even here of 325 per cent is too serious to be lightly dismissed.

These rules are empirical, faulty in conception, wrong in

principle, and dangerous in their actual working out. Is it any wonder we have a few therapeutic nihilists when the ablest minds of the past centuries have apparently been unable to formulate any better rules for dosage than these? What other branch of modern science would tolerate such loose-jointed formulae? It recalls the story of the Irishman who was sent out to measure the length of a wall. When he returned he said, "Sure, and it measures four short paces, the length of me shovel, two bricks and a brick-bat, and a thrifle over."

If we condemn certain formulae we should be in a position to offer something better; otherwise, it were wise to remain silent. Consciously or unconsciously, in prescribing for a child, or for that matter for an adult, we are to a large extent influenced in our estimate by the size and apparent body weight of the patient. From this alone, it is the easiest thing to formulate a rule for dosage. Disregard the *age* entirely and give the dose in proportion to the *weight*. The average weight of the human adult, including males and females, has been determined to be 130 lbs at the age of 25, the period of full development: this is an approximation but all authorities are in practical agreement. The average infant, male or female, is a trifle over $6\frac{1}{2}$ lbs or $1/20$ th of the adult weight. The dose for an infant is therefore $1/20$ th of that for the adult. If the child is over or under the average, the dose will vary accordingly; thus, if he weighs 13 lbs, the dose would be $1/10$ th of the adult dose, this regardless of his age. It is merely a problem in mental arithmetic reduced to its simplest form.

Our veterinary friends give domestic animals doses approximately in proportion to the body weight as compared with man, which can be readily demonstrated by reference to any veterinary dose-book. The variations will be found to be due chiefly to the greater or less susceptibility of certain animals to the action of certain drugs, like that of carnivorous animals to strychnia. Why not, like the "horse doctors," exercise a little plain ordinary horse sense? No radical change

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in dosage is to be anticipated, merely greater ease, accuracy, safety, and uniformity in the dose so estimated. This method is applicable simply and directly to all ages and conditions, from the seven-month premature to the overgrown giant.

Any system of dosage must take into account individual susceptibility and, in the case of children, certain facts. Children do not bear powerful narcotics well, notably opium. On the other hand, they bear proportionately very large doses of the milder purgatives, belladonna, arsenic, mercury, emetics, etc., due in part, no doubt, to their more active eliminating organs. It is next to impossible to salivate a child.

There are other considerations to be taken into account. The dose of antitoxin, for instance, is to be determined not so much by the weight of the child as by the amount of toxins in the system which it is needful to combat. The same would be true in giving an antidote to various poisons.

Again, while 5-grain doses of santonin are commonly prescribed for adults, the National Dispensatory and other works of the kind state that it should not be prescribed in larger doses than $\frac{1}{4}$ grain for children! If we are giving santonin to produce systematic effects upon the child this may be proper, but it is doubtful if a large and healthy lumbricoid worm in a child is any more susceptible to the action of santonin than one of similar vigor in the digestive tube of an adult. Santonin is given for the worms, not for the child, and it is hoped that the prescriber will bear this in mind and follow it up with a sufficient dose of a brisk purgative to prevent its absorption and consequent systemic effects upon the patient. A quarter-grain dose of santonin is illogical, and practically useless. Any good effect resulting apparently therefrom may be attributed to the calomel commonly given with it or to the brisk purge which follows its administration. One of the best things about advice is that you can take it or leave it alone.

I recently saw a patient for whom another physician had prescribed ten-drop doses of an excellent and carefully stand-

ardized preparation of digitalis. The remedy was clearly indicated and should have taken effect, but the patient had not responded. I asked the nurse to measure ten drops which she accordingly did with a medicine dropper. I dropped ten drops from the container bottle into a spoon and drew it back up into the dropper. From this, I again dropped it, getting 31 drops. The patient had been getting a little less than one-third of the intended dose. These proportions will vary with the specific gravity of the liquid, the fluidity of the preparation, and with the varying shapes of the medicine bottle lips and droppers.

Again, patients frequently come to our offices showing some over-effect of the remedy we had prescribed. I believe doctors are far too prone to attribute this to individual susceptibility. I have usually found that the spoons they had been using were much oversize. Prescriptions are written on the supposition that a fluid drachm is the equivalent of a teaspoonful. A four-ounce bottle should contain 32 fluid drachms. This, if taken three times a day in "teaspoonful" doses, should last one dose under eleven days. Commonly, patients will empty such a bottle in a week, showing that they were taking much more than a fluid drachm to each dose. Spoons are not made to any standard gauge and commonly run oversize. The result is often unsatisfactory and, as a rule, the doctor gets the blame.

Speaking of pills, which I wasn't, any self-respecting pill will naturally refuse to go down if placed on top of the tongue. Put it under the frenum linguae (the tongue-tie) in the bottom of the mouth just back of the lower front teeth, take one good swallow of water, then look for your pill. If you left it in position you will never see it again.

Many tablets are more quickly soluble if uncoated but, if of an absorbent or chalky nature, are prone to lodge in the gullet and cause irritation. This can be obviated by buttering them. Careful and habitual inspection of the tongue will often give the physician valuable diagnostic and prognostic

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assistance. Some writers lay much stress on the shape of the tongue, whether narrow, pointed, broad, flat, etc. It must be borne in mind that the shape of the tongue varies to a great degree with the individual, and is therefore susceptible of misinterpretation. Until such time as mass production makes human beings to gauge, our tongues, like our noses and similar gadgets, will be subject to infinite variations in shape, none of which is necessarily of pathological significance. We should not place too much reliance on the shape of the tongue unless we have convincing reason to believe it a departure from the normal. I could indentify many of my acquaintances by the shape of the tongue and its superficial characteristics a la Bertillon. A sharp pointed tongue, or a broad flat one, may mean no more than auburn hair or a squat figure, neither being indicative of ill health.

Jagged teeth, ill-fitting dental plates, a host of local and general conditions may modify the appearance of the tongue. Nevertheless, inspection will often afford useful indications for diagnosis and treatment, if proper allowance is made for individual characteristics and for local or transient conditions. It is to be remembered that many people, apparently in excellent health, have a tongue that is habitually coated.

Uncle Ephraim said to me the other day, "They was a car drove up here this mornin' with a Michigan number plate on it an' a big, fat Michigander an' three Michigeese in it. They was lookin' fer old Doc Jenkins who was here gettin' his tires blowed up. The old woman, she 'most talked an arm off the doctor. Bimeby he winks at me an' says to her, polite as could be, 'Now, madam, I've heard your tongue. Let's see it.'"

Dr. Jenkins arrived one morning at a country store just in time to get the final chapter of a long discourse by the wife of the storekeeper on her many and varied ailments, among which was a chronic and incurable case of high-frequency of the tongue. As the doctor entered the store she said, "There's the doctor now. *He* knows. *He* can tell you

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all about my case. Doctor, haven't I had every disease and 'most every operation any mortal woman *could* have and still live through it?"

"No," said Jenkins, "I can think of two right offhand that you've never had yet."

"Well, I'd like to know what they could be."

"Lock-jaw and tongue-tie," said Jenkins. Her husband, who was sitting on the counter, fell off in some kind of a fit but was resuscitated.

I can readily believe that some of my readers, who have been dignified for so many years that their spines are ankylosed and cannot unbend, are quite certain to censure me for indulging in "cheap, coarse and vulgar humor." Some of these irreproachables appear to me to have the exact expression of a wall-eyed pike. It is possible that they were picked before they were fully ripe. If they have waded through the preceding dry and stodgy dissertation on remedial agents and have survived, it will do 'em good; even an occasional spasm of anger and disgust is better than a wan and cadaverous solemnity.

"A merry heart doeth good like a medicine."

Proverbs xvii: 22

This may even include a measure of slapstick comedy.

XXVII

ANAESTHESIA

THE matter of anaesthesia, general and local, is too broad a field for a book of this character, but a few remarks may not be misplaced. Ether is on the whole the anaesthetic most frequently used. I began giving ether in 1880, giving it for various physicians in the community. I have never lost an ether case. Chloroform was formerly considered safe for children but the danger is merely somewhat less than in adults. I have had a few chloroform cases that scared me stiff though they all fortunately recovered, but I have no fear of ether. I not infrequently give morphine and hyoscine an hour or so before etherization, but only in a small percentage of the total number, where I fear post-anaesthesia vomiting, where the patient is very nervous, or for other very definite reasons. It has a very happy effect and a much smaller amount of ether will suffice.

In a general way, alcohol and ether have many points of resemblance, bearing in mind that ether, being much more volatile and diffusible, is naturally much swifter in its action. To all intents and purposes, ether narcosis is quite similar to the corresponding condition in alcoholism, where the patient gets dead drunk following a period of excitation. Likewise the sobering-up process is much the same. During etherization, absolute quiet is essential. Any loud noise or excitement will usually make the partly anaesthetized patient (like the semi-intoxicated person) quite unmanageable.

With due allowance for other considerations, the more rapidly ether is given the smaller the amount required to attain the maximum effect, and the quicker and more satisfactory the recovery. It should be given intensively, the aim being to

get the patient dead drunk as rapidly as possible. This requires courage and understanding. The rabbit-hearted soul who is afraid to push the ether, giving it in insufficient quantity, wastes much valuable time (for his associates, at least), uses far more ether than he should, never gets his patient properly anaesthetized, poisons the patient's system with it, and the subsequent recovery is slow, tedious, and distressing. In other words, instead of getting his patient fully and completely intoxicated in the shortest possible time, he keeps him on a protracted spree which ends with an attack of the jim-jams.

Chronic alcoholics take ether badly and this we would naturally expect. They have developed a sort of first-cousin immunity to its anaesthetic action. Many who give ether advise the patient to keep taking long, deep breaths. This advice, if followed, invariably results in entire cessation of respiration for a time. The etherizer becomes alarmed and adopts measures to start up the breathing when its cessation is merely the result of over-oxygenation. The patient should be told to breathe naturally.

Many people take ether badly through plain terror of the anaesthetic. In every community there unfortunately are a few silly people who, instead of thanking an All-Wise Providence for the merciful boon of anaesthesia, are prone to broadcast weird tales of their sufferings while taking ether; this, since they cannot claim that they felt pain during the operation. In consequence, many nervous people become panicky; they expect to have a terrible time under ether, they fight the anaesthetic and, for this reason, their expectations are realized to some extent.

In the early stage of etherization, the irritant effect of the ether on the mucous surfaces of the organs of respiration produces a choky sensation, as they term it, and they naturally attempt to turn the head aside or push away the mask. It is well, just before starting the ether, to reassure the patient, gain his confidence, tell him as nearly as you can just what he may expect. Explain to him that it is much like taking a

cold bath, that once he "gets over his dread," as the boys say when they go in swimming early in the season, his troubles will be over, that once he gets the ether well down in his lungs the smothering sensation will disappear, that the remedy is merely to take four or five long, deep breaths, after which he will have no further trouble, but that he must not expect to go to sleep for some little time. Calm his fears, win his confidence and coöperation, so that he will take it trustfully and with composure. With children too young to accept such advice, it is often well to suggest repeatedly that they "blow the ether away."

Primary anaesthesia may be induced with ether and is effective for very brief operations such as incising an abscess. The patient is directed to hold up one arm, to draw a number of long, deep breaths through the ether cone. When the arm becomes rigid, sways or falls, make the incision immediately. Consciousness is not lost but sensation is blunted or lost for a few moments. The condition can be produced in a similar way without ether. When a pin-prick is no longer felt, operate. I find the ether method more satisfactory, perhaps because the patient has greater faith in it.

As regards the use of local anaesthetics, a careful study of some of the standard textbooks on local and regional anaesthesia is essential to good work. While for general purposes novocaine, or some similar preparation, is ordinarily to be preferred, being less toxic, for many purposes cocaine is still our best agent. Much that has been written regarding the toxicity of cocaine is true only in a measure. We have always been afflicted with all kinds of heresies based on half-truths and therefore sufficiently plausible to be accepted without qualification. Cocaine is a peculiar product in that it is decomposed very readily. It is found in the market in an impalpable powder, in fine needle crystals, in fine granular crystalline formation, in coarse lumps like alum; some makes are odorless, others have a peculiar sweetish odor; some forms show marked toxic effect, others seem quite free from such

action. Made up in solution with distilled water, it begins to decompose at once and in a short time develops marked toxicity while still retaining its anaesthetic action; later when decomposition has progressed further even this is lost. Being expensive, it not infrequently happens that some of this solution, not used at the time, is set aside and used later, which is a dangerous practice.

It is an open question if some of the preparations on the market, which vary so in their physical aspects, are not to some extent decomposition products due to changes occurring in process of manufacture. In 1886, I began the use of cocaine as a local anaesthetic, and realized almost immediately that it would become contaminated and spoil in solution almost as readily as milk, becoming quickly quite as dangerous to use. I added a few drops of carbolic to an ounce of four percent solution and set a bottle aside for a year as a control experiment. At the end of that time, I found it in perfect condition, and I have so continued to prepare it since that time. Gluck subsequently pointed out the same thing, and, since publication of his article, my bottle of standard cocaine solution has been labeled Gluck's Solution.

Cocaine solution made from the large alum-like crystals and preserved by this method keeps indefinitely in perfect condition, and is practically non-toxic in any dosage up to three-quarters of a grain of the alkaloid. When used in the eye, it causes rather more smarting than the plain solution in distilled water, but this is the only disadvantage I have observed, after using it since it was first brought into general service.

One patient, upon whom I used ten minims of a four percent solution of cocaine to remove a disfiguring mole, broadcast the news that it had affected her dreadfully, making her short of breath "and all of a tremble." It so happened that I saw her crossing the street to my office and she was already agitated and short of breath. An agent that will cause these distressing symptoms a full half hour before the instruments

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are sterilized and the cocaine injected is surely to be avoided.

Local anaesthesia, nerve blocking and spinal anaesthesia, each have advantages in properly selected cases. Local anaesthesia is of excellent service in tenorrhaphy operations. When a single flexor tendon is severed, the upper end may be made to protrude by forcibly extending the adjoining fingers. Where the wrist is slashed through the region of the annular ligament, it is often a matter of hours to match up and properly suture a bunch of severed tendons. Aside from the risk of protracted general anaesthesia, it is much easier to do these cases under local, since a conscious patient can greatly assist in identifying the upper end of a tendon by attempting to move the finger to which it is normally attached. Attempts to do a circumcision, under local, are usually unsatisfactory unless a rubber band is placed about the base of the organ. With practice, one can grow very proficient in the use of local anaesthesia and secure extremely satisfactory results. At the present time I am using metycaine with satisfaction.

Spinal anaesthesia and nerve blocking require too much space for a work of this kind and the reader is referred to the textbooks of Labat and other authorities for guidance. Many new anaesthetics and new methods of anaesthesia are being tested out but I have no desire to air any half-baked opinions on these until they have been thoroughly time-tested.

In a general way the matter may be summed up thus: Chloroform is agreeable to take, its administration is simple, but the margin of safety between the anaesthetic and the lethal dose is too narrow. It is a tricky agent, giving little warning of danger. It is occasionally followed by fatty degeneration of the internal organs. It is non-explosive but, in the presence of heat, may generate a poisonous gas. Its use is too risky, like sending in a mail-order to Sears-Roebuck or Montgomery Ward for a wife; you may get something that you do not want at any price.

Ether, save for its explosive nature, which can be guarded

against, is safe. It is efficient and easy to give. The margin of safety is wide. It is not agreeable to take unless some preliminary treatment is used such as morphine and scopolamine or avertin, or it is preceded by nitrous oxide gas. The latter is not practical when one has to give ether in some isolated farmhouse. Ether, given intra-pharyngeally, has advantages in nose, throat and jaw work. It is usually given by means of a catheter through the nose and an electrically driven pump. Given by the rectum, it is prone to create irritation. On the whole, ether is comparatively harmless and, when given by inhalation, can be at once withdrawn if need be.

Scopolamine and morphine, where one is engaged in country practice, being frequently short-handed, has given me excellent service and satisfaction. While I have used it extensively and have never seen any ill-effects from it, I would hesitate to recommend it as a routine procedure even in the way of a pre-anaesthetic.

When it comes to making a choice of the anaesthetic to be used in a given case, one must exercise the best of judgment and remember that here, as elsewhere, the safety of the patient is of paramount importance. I read today, "It is my opinion that there is only one place to give an anaesthetic, except, of course, in an emergency, and that is in the hospital where all clothing can be removed and the proper care and precautions taken." Although this has a slight Utopian flavor, it is merely that particular writer's opinion, as stated, and therefore I make no comment.

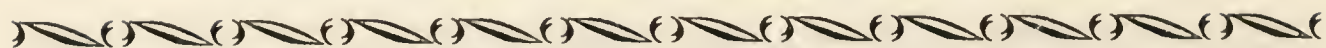
One day I was noting the exceedingly elaborate preparations for an operation by a prominent specialist and, merely by way of contrast, quite innocently told him of a similar operation I had done single-handed, on a rude table made of unplanned boards, under the canopy of the sugar-maples at a construction camp.

"But a surgeon has no *right* to operate under such conditions. Human life is too sacred," he thundered, towering over me and pointing his finger at me accusingly.

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I was an older man than he and I simply smiled and suggested that "such conditions" would have been equally unsuitable for the funeral which would have been inevitable had I not operated without delay.

It seems unfortunate as well as unintelligent that so many of us are insistent on measuring our neighbors with our own yardstick.

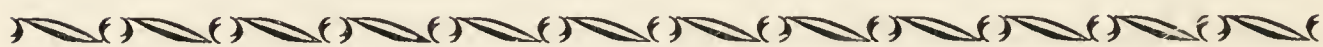


XXVIII

COD-LIVER OIL

“Hexcuse me, Monsieur le Docteur, hallowing me to be
de judge.”

MRS. PRUDHOMME OF ST. ANICET



THE use of cod-liver oil in the coastal countries of western Europe, as a medicinal agent, dates back, it is stated, some 1800 years. So far as I know, one of the first authentic records is that of Dr. Samuel Kay, of Manchester, England, 1752-84. It came largely into use for the “cure” of tuberculosis and it acquired a reputation for being extremely unpalatable, which it was at that time. The codfish were dressed on board of sailing vessels, the livers were thrown into a big cask and, on return from the voyage, the oil was expressed from these rancid livers. It was an evil-smelling and brownish oil, utterly unlike that of the present day when it is to be had of fine quality, made with scrupulous care from fresh livers. It comes in hermetically sealed, tin-lined barrels and, when fresh, the odor is not at all offensive. I have dropped a weighted strip of newsprint to the bottom of a full barrel and have been able to read the print. While on exposure to the atmosphere it can develop a strong fishy odor and assume a yellowish tinge, the fresh oil has less fishy odor than canned salmon or sardines and is practically tasteless.

Give a dog a bad name and it will stick to him as long as he lives. In the case of this oil, the name has stuck longer than an alligator’s age. Once Mrs. Soandso gets the reputation for making bad butter, any butter, no matter how good it may be or who made it, will be repugnant provided her label is attached. Children almost invariably take this oil very well, if and provided these big-eared little pitchers have not

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been prejudiced by what they have overheard from their elders.

I was advising cod-liver oil for a little girl at whose bedside I was sitting and the nurse exclaimed, "Oh, that horrid stuff!" I told the nurse that I hoped she'd have a whale of a time giving it after pulling that boner.

It contains, aside from its fatty content, small amounts of iodine and phosphorus in organic combination, together with extractive matter and a few alkaloids. Our present knowledge indicates that its efficacy depends largely on its vitamin content, chiefly A and D. Viosterol is now usually supplied in the potency of 250D. It has proven of much value, particularly in rachitis, but may not fully represent or take the place of cod-liver oil since the oil is rather complex in its structure. Of late the oils from halibut and other fish livers have been investigated as to their vitamin strength and are coming into extensive use.

Cod-liver oil is essentially a nutritive remedial agent. It is of much value in chronic pulmonary affections, chronic bronchitis, emphysema and, when well tolerated, in tuberculosis. In rheumatic affections and in rheumatoid arthritis it is of much service. It is of benefit in a wide range of disorders of the nervous system. Its efficacy in rickets was demonstrated beyond all question many years ago. In the so-called scrofulous conditions of children it has been our chief reliance, such conditions as corneal ulcers, enlarged lymphatic glands, catarrhal affections, bad teeth, scaly skin diseases, etc. We no longer employ the word scrofula but the meaning should be clear. In our Northern climate, where sunlight is deficient during the fall and winter months, it is an axiom that all of our children need cod-liver oil. At present the trend seems to be to omit giving cod-liver oil during the summer months. It is a food and, if the reasons so far given are valid, they should apply to other foods as well, which should likewise be omitted in summer, a manifest absurdity.

One very capable physician told me that he did not believe

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in cod-liver oil. I asked him how much he had used it and he told me that he had prescribed several bottles of it many years ago and had then discontinued its use. I said that my pharmacist informed me that my patients used an average of a barrel a year of the clear oil, not to mention the various emulsions and other preparations of which it was the chief constituent. This pharmacist has been in my personal employ over thirty-one years. The conclusion to be drawn need not be specifically pointed out.

When cod-liver oil is given in the natural state, a little salt on the tongue takes off the flat taste of the oil. The fishy taste will not be much in evidence if the oil be of good quality and strictly fresh. It should be given before meals. It is not digested in the stomach, and if given with the meals, must remain there until the food passes on, hence gaseous eructations may cause a dislike for it. If given ten or fifteen minutes before meals, this seldom occurs, and when it does, should arouse suspicion that the previous meal is not fully digested as yet.

Given in combination with malt extract, it is usually very well borne; this for several reasons. Malt extract not only provides an excellent vehicle for it but has a solvent action, to some degree, on the oil. The diastasic properties of the malt extract are valuable in many cases. When we think of a digestive agent, our first thought is of pepsin as a rule. Since from seventy to eighty percent of our foods are in the form of carbohydrates, it will be seen that diastase has a much wider scope than pepsin, the action of the latter being chiefly confined to the lean of the meat, the white of the egg and the casein of the milk. Malt extract has a definite action, albeit somewhat limited, in the assimilation of fats.

Malt extract with cod-liver oil seldom "repeats" and in most cases it is a wonderful flesh producer. It can be given freely without evil effect. I had one patient who took a pint bottle every day for some length of time. As frequently found in the market, it is open to several objections, the chief

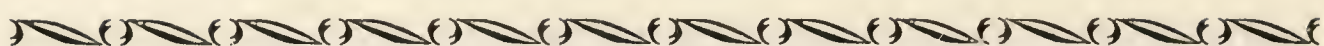
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being that it is often very old, with the malt extract gelatinized and inert and with the oil content rancid and offensive. The druggist may not be at fault. One experience I had may be illuminating. I ordered several cases of this compound, through a jobber, specifying the product of a well-known manufacturer of pharmaceuticals, one with a well-earned reputation for high-grade products. Repeated complaints from my patients finally led me to investigate and I found that this lot, bought in unbroken cases, with fresh-looking labels and to all external appearance in perfect condition, had been manufactured thirteen years before it reached my druggist.

The manufacturers promptly replaced the goods with a fresh supply free of charge, at the same time very properly disclaiming any responsibility for a product of this nature which had been kept in storage under unknown conditions for so long a time. Where had these cases wandered in the interval? Echo was the only answer. At any rate they reminded me of Steve Russell's teeth. He said he had a nice set of artificial teeth but they had been made for his grandmother and did not quite fit him.

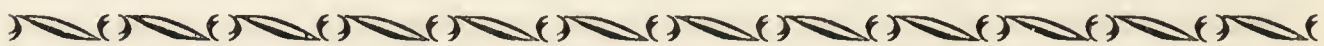
Another objection to this preparation is that the original percentage of cod-liver oil has been materially reduced. In one instance it was cut down from twenty-five per cent to ten per cent without this being stated on the label. The excuse given by the maker for this reduction was that it was merely to make it more palatable, adding that economy was not a factor since the malt extract cost more than the oil. All of which may have been true but the dose of the oil was too small to be very efficacious.

I have been able to overcome these difficulties by a special arrangement with a manufacturer whereby I am supplied with a thirty percent cod-liver oil content. In this way I am assured, not only of an adequate proportion of oil, but of a fresh and active diastasic malt extract.



XXIX

POWDERED BEEF BONE



MUCH has been written of late years regarding deficiency in calcium salts. A review of the literature on this subject is not necessary here since I think that we are all prepared to admit that our present-day dietary is deficient in the mineral intake. It seems self-evident. Our dentist bills are enormous. Rickets, osteomalacia, bow-legs, knock-knees, delayed closure of fontanelles, retarded dentition and imperfect teeth, the dental neuralgia of pregnancy, dental caries, pyorrhoea, crockery teeth on vulcanite plates, caries, necrosis and delayed union of fractures, and many other affections attest this. The almost universal use of calcium lactate, calcium chloride and other lime salts, the syrups of hypophosphites of calcium and magnesium for various conditions from rickets to hemophilia, is added evidence. Of late, a large number of diseases the origin of which had been a puzzle, have been proved to be due to calcium deficiency.

Take another slant at this question. How often do you see a dog with decayed teeth, or for that matter any other domestic animal? The primitive and savage races are largely exempt from dental caries. If we filed our teeth to sharp points, as many of these do, how long would we have them? (Though I did once dig up a human skull from an ancient burial mound in the Florida Everglades, and found a well-marked cavity in the second lower molar.) Why are they so practically free from dental decay? It is largely a matter of diet.

Take the matter of dental caries and pyorrhoea. The dentist tells us that only by the most careful hygiene of the mouth can these things be prevented; that they are due to invasion of various germs; that once the enamel is destroyed,

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it is never regenerated; that we must never crack nuts, or be otherwise rude to our teeth, lest bridge-work or a dental plate befall us; that we must never use a gritty tooth powder.

What about the dog who never uses any of the much-radioed dental creams, who rolls his bone in the grit of a macadam road and crunches it down? Who supplies him with gold crowns? Does he brush his teeth thrice daily with Glisterine? or Get-hep-so-dent? His excrement, when exposed to the weather, turns white from the excess lime which it contains. What of the horse? When his teeth are gone, he is usually scrapped, sometimes to make one brand of beef extract, as I happen to know. But when his teeth are worn out, and he is fit only for the tannery and the glue factory, he is showing many other evidences of a ripe old age. A man is as old as his arteries, and a horse is as old as his teeth.

Just so long as we de-mineralize our wheat, giving the bran to our domestic animals, just so long as we eat the meat and throw the bone to Fido, just so long, I believe, we and our children will go to the dentist. "When the enamel is gone, the case is hopeless." When the blacksmith wears out the skin on his palms, do they remain forever raw and bleeding? Are cows subject to pyorrhoea?

There is no greater heresy than a half-truth. It seems to me that the cause lies far deeper than the prevalent view; that it is more a matter of defective nutrition coupled with a faulty metabolism. If you keep your chickens confined all winter in our cold climate, without plaster, bone meal, or oyster shell, they lay soft-shelled eggs. Feed our women on sugar, candies, white bread, from which most of the phosphates have been removed, on marshmallow creams, on decorticated rice, and they will lay soft-shelled eggs in the way of children who cut teeth with difficulty, whose teeth are discolored and blackened when they first appear, children whose fontanelles fail to close on time, whose legs crook under them, who develop lateral curvature.

The pregnant mother is prone to dental neuralgia and

caries. She tells us that she had good teeth until she raised her family. A mother will sacrifice much for her children, some of it unconsciously. She gives of her teeth frequently to supply mineral elements for the child unborn. She suffers from dental neuralgia, from lumbago-like pains in the back, from sacro-iliac trouble. If I recall aright my Sunday School lessons, the Israelites were given the task of making bricks without straw. Is this horse sense, cow sense, or non-sense?

What is the remedy for calcium starvation? Or, is it wholly a calcium starvation? Chemists tell us that bone, aside from its organic constituents, is chiefly composed of calcium phosphate in the form of tricalcium phosphate. Next in order comes calcium carbonate with a moderate amount of calcium fluoride. Then magnesium phosphate, and a host of other mineral ingredients which it is not necessary to mention, others as yet undetermined. Some of the latter, like the iodine in the thyroid, though small in amount, may be indispensable. Are we quite sure that the administration of a calcium salt with or without violet rays, with or without magnesium, the vitamins, is all that is required? We have not yet succeeded in producing a synthetic egg, a good milk from coal-tar, a juicy sirloin from sawdust, by any cracking process as we produce gasoline. The time has not yet arrived when calcium gluconate will supply all deficiencies. We make vanillin from coal-tar, but we are as yet unable to make a synthetic vanilla bean, or even the ordinary bean of the Boston addict. The synthetic breakfast, the chemical dinner, the coal-tar supper is still in the misty future.

We still lack knowledge of the exact composition of bone and dentine. A slight difference in the proportions of the atoms in the molecule make the difference between drinking water and peroxide of hydrogen, between calomel and corrosive sublimate. The difference between bone, dentine and enamel is largely a difference in proportion of mineral and animal matter, a difference in density and other physical qualities, likewise, no doubt, a difference in the combinations

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of the atom in the molecule. Until these essential differences are more fully determined, we will do well to depend on natural foods rather than chemical compounds. We will get more consistent returns, better dividends on the whole, by giving bone flour rather than calcium salts made in the chemical laboratory.

Bone meal, bone flour, prepared from fresh clean bones, contains all the necessary salts in proper proportion for assimilation. It is a natural food, physiological, harmless, can be given safely in any dose, in capsule, in tablet, in meat gravy, in cod-liver oil emulsion, in various foods. When given in a liquid mixture, some preservative must be added if it is not to be used at once, since decomposition may occur. It is, of course, incompatible with acids.

In certain conditions, it is as near a specific cure as anything we are likely to meet with in this vale of tears. In the dental neuralgia of pregnancy, I give one 00 size capsule of it once a day. It has been my frequent experience that the patient told me the neuralgia disappeared after taking the first capsule. In no case, so far, has it failed to furnish much relief. I have been testing it out in the morning sickness of pregnancy of late. I can only recommend it as worthy of further trial. One swallow, in capsule form, does not make a proper summary, and I have not yet collected sufficient data to care to put myself on record as to its efficacy in pyorrhoea. I know what it will do in defective dentition. I have treated many cases of delayed union in fracture cases. In no case where the bones were in reasonable apposition have I failed to get sufficient callus formation and an eventual good union. I do not refer to cases where muscle or other tissue was interposed between the fragments. Such instances are not properly cases of delayed union. Here, bone meal would be useless.

In 1899, I had a case of acute osteomyelitis involving the entire shaft of the femur in which I cut from the great trochanter down the outer aspect of the thigh to the knee,

channeling the bone through the length of the shaft. I put him on bone flour and got a complete involucrum through which I chiseled later, removing the necrosed shaft. He made an excellent recovery without shortening, deformity, or any loss of function. He became a baseball player.

Another typical case. A young girl on the St. Regis Indian Reservation had a neglected case quite similar in every way. Spontaneous fracture of the femur occurred while she was very ill in bed. I was called. I drained the abscess, put the leg under extension, fed her bone meal. Later, the shaft was removed piecemeal, since it was badly disorganized. She was married this year. Her leg is straight; she is free from any lameness or disability. Beyond the scars of the operation, there is no deformity.

Bone flour of good quality is procurable from some of our large meat-packing houses. It is inexpensive. It is safe to use under almost any conceivable condition where such treatment is indicated. It has proven itself of great service in my practice. I can recommend it with the utmost confidence as above indicated, and it is deserving of a more thorough trial than at the hands of a few general practitioners. In this way, and in this way only, can its utility be either confirmed or disproved, its use extended, and its proper scope and limitations defined.

I have purposely omitted any general discussion of the therapeutic action of the calcium salts, the action of the parathyroids, etc., for obvious reasons. I only hope that someone with better facilities will investigate bone flour in conjunction with the violet ray and the action of the glands referred to.

XXX

IODINE AND THE IODIDES

IODINE was discovered in 1811 by M. Courtois of Paris, a manufacturer of saltpeter. It rapidly came into use as a liquefacient and resolvent, to employ the terms in common use at that period. It was reputed to be a stimulant of the lymphatic glands. Pereira states (1845), that it had proven itself far more successful in the treatment of goiter (at that time usually designated bronchocele) than any other remedy offered. Lugol's solution, still freely used by the profession, came into popularity over a century ago.

Laplace, the astronomer, said, "What we know is nothing. What we have to learn is immense." In medicine this is applicable to iodine and its compounds to a degree. Many modern writers on materia medica, while devoting much space to the physiological action of most drugs, cannily sidestep the action of the iodides. Others frankly acknowledge their ignorance of the therapeutic action of iodine. Still others indulge in a lot of verbiage without arriving anywhere. Some of the latter I have read in both directions, then every other word, without any satisfactory result. The older writers call it a resolvent and an alterative. Present-day authorities contemptuously refer to these terms as vague and obsolete, all of which may be true now, but if one will take the trouble to look up the context in these old books he will find very clear definitions of what was meant by these terms. I will continue the use of the word alterative until such time as a better one is suggested. One recent writer of repute says iodine is a general detoxicant which, in so far as it goes, is not half bad. Its application is not sufficiently broad, however.

The writers of today say that "it increases the destructive

or catalytic side of metabolism of all sorts, particularly of diseased cells," "it promotes metabolic activity, stimulates resorption and secretion," "it hastens the elimination of waste products," "it assists oxidation of protein and autotoxic excrementitious substances."

All admit a special action on lymphatic and glandular tissues, without being too definite as to the exact way in which it acts and, taken as a whole, the literature on its action is unsatisfactory. Politely suppressing a yawn I would suggest that, winnowing the wheat from the chaff, or boiling it all down, the difference between the views of the older writers and the newer authorities, between either of these and the layman's calling it a blood purifier, is much the same as the difference between a young cat and a kitten. Our knowledge is shy a suspender button or two. There is an old proverb, "Why worry over the bird in the pot? It will improve in the boiling."

The action of the iodine preparations is seemingly paradoxical. While many complain of a bitter taste in the mouth when taking the iodides, I have almost invariably found that patients who came to me complaining of a bitter mouth, together with other symptoms, were promptly relieved. This symptom, a bitter mouth, is in itself a clear indication for its use. From the time of Lugol it has been noted that in some cases it was flesh-forming, in others it reduced obesity. It reduces high blood pressure in plethoric and gouty people. In those with venous stases, varicosities and low blood pressure, it increases the tension. It sometimes augments and frequently relieves evidences of mercurialism. How can these apparent contradictions be explained? It is not necessary to resort to the homeopathic theory. It has a known action in rendering mineral salts soluble in just the same way that it will remove the supposedly indelible stains of nitrate of silver.

If the system is saturated with mercury and the iodides are given freely, it will liberate mercury so rapidly that salivation is likely to result. Smaller doses in milder cases of mercurial-

ism liberate the mercury so slowly that it is eliminated gradually without ill effect. I doubt if the iodides are capable of producing salivation unless mercury is already present in the tissues. If we accept this view of its paradoxical action in the case of mercury, by analogy its effects on nutrition and blood pressure are explainable as being due to the elimination of auto-toxins and other poisons.

Solis-Cohen says that iodine can be detected in the urine within two or three minutes after it is taken. It appears in all the secretions and excretions and can be found in practically all the organs and tissues. Elimination is rapid and practically complete in a few days, though traces may show for several weeks. If the kidneys are faulty, as may be the case in elderly people, elimination may be slow and cumulative effects can occur. My personal opinion is that it is an eliminant in the broadest sense, having the action of a glandular stimulant with particular emphasis on the ductless glands.

Beyond all shadow of doubt iodine is one of our most useful remedies and one which deserves a wider application than generally accorded it. It undoubtedly favors leucocytosis and has a beneficent action in many conditions which, in the meagre light of our present knowledge, is not readily explained. It is quite capable of producing iodism if given in sufficient doses to produce the drug effect and this over-dosage varies within exceedingly wide limits, some patients being very sensitive to its action, others exceedingly tolerant. In giving the iodine salts, an excess of iodine or the presence of iodates may cause intolerance. On the other hand, various symptoms classed as evidences of iodism may be taken with a measure of doubt.

The iodides are very useful in many cases of cardiac troubles and this is particularly noticeable where there are asthmatic manifestations in evidence. It is one of our standard remedies in chronic bronchitis and those cases in which hard, clear "pearls" are expectorated respond promptly to its use.

It is an excellent remedy in certain cases of ulcer of the

stomach and some other gastric troubles. Some of these are undoubtedly of syphilitic origin or complicated by syphilis, but others, which are Wassermann negative on repeated trials and practically beyond suspicion, are likewise equally benefited. In middle ear disease and a threatening mastoiditis, I have repeatedly seen a prompt improvement under the iodides. Women, with that disorder of menstruation which is manifested by a menstrual flow which is scanty, thick and nearly black in color, are promptly relieved by their use. It has been a regular experience with me that people showing manifestations of an allergic nature, all benefit by a course of iodides. It is to be remembered, however, that I practise in the goiter belt. During the World War, in examining drafted soldiers, it was found that the proportion of goiter cases was one among those who came from the coastal regions to seventeen for those who came from the interior.

The usual symptoms of iodism appear in about the following order: coryza, frontal headache, pain in the ears, suffusion of the eyes, bad taste in the mouth, acne, occasional salivation, or at times soreness of the gums and tenderness of the tooth sockets, bladder irritation, a pemphigoid eruption with a gangrenous-looking base, atrophy of the mammae or testicles, impaired digestion. I have never seen the trophic condition, and the impaired digestion occurs as a rule only when given in too great concentration. The tenderness of the teeth and gums, I have only found in those who had previously been under the influence of mercury, but it is quite possible that it may cause this independently.

One thing must be kept in mind, that there is no known dose of potassium iodide, or the iodides in general. In some cases, I have found the susceptibility so great that the patient would not bear more than a grain or two of the iodide within the twenty-four-hour period. In other cases, there seems to be no limit of tolerance, and I have not infrequently given an ounce in the twenty-four hours and kept this up for long periods, with only the happiest results. Again, a case that

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may bear large doses at one time may, later on, tolerate only small doses. A preparation with such disadvantages may seem hardly worth using, yet its beneficent effect is so marked in such a wide number of disorders in which no other line of treatment seems to serve, that despite these drawbacks we must still continue its use.

The only satisfactory way to give the iodides, providing one has time enough, is to begin with small doses and to push them steadily up to the amount needful to control the condition or (and this is usually the equivalent) to the limit of tolerance. The bitter taste in the mouth of which some complain, will, as a rule, pass off under their continuous use. At any rate, it may be disregarded since there is no recorded case of anyone who died of a bitter taste in the mouth. An acne, if not too troublesome, may likewise be disregarded. In nephritis, if bladder symptoms come on under their use, they should be discontinued, or the dose very greatly reduced. If we have an urgent case, however, there need seldom be any hesitation in starting with good doses, since the symptoms of iodism, while they may be very disagreeable, are not dangerous and rapidly disappear on discontinuing the iodide.

In recommending the use of potassium iodide to other physicians, I have commonly met with the objection that "it is so hard on the stomach." This is in a sense true, but it is not a difficulty inherent in the remedy, but due to faulty and unscientific methods of administration. This also applies to many other salts. Salt and water, in proper strength, or rather in sufficiently weak solution, makes a very comfortable and soothing eye lotion, but do not use strong brine, if you value your comfort. Potassium iodide is commonly given in thick syrups like the compound syrup of sarsaparilla, for instance, in order to disguise the taste. Such a mixture is not only as a rule extremely unpalatable but is, on account of its concentration, very irritating to the stomach. It should be given in dilute solution of no greater saline strength than

would correspond to that of normal saline solution. Such an isotonic solution is non-irritant. The taste of a well-diluted solution is not disagreeable to most people if two grains of saccharin are added to each ounce of the iodide. The further addition of a drop or two of tinct. nux vomica is advisable for those objecting to the sweet taste.

As previously stated, it is commonly, though not always, advisable to begin with a small dose and gradually increase. Usually after taking it for a time, the patient acquires a tolerance of it that was not present at the start. Potassium iodide is an eliminant of poisons, it removes the scale from our boilers, or if you prefer, the carbon from our cylinders. The fact that it is more apt to produce disagreeable effects when its administration is first started is quite easy to understand, if we bear the action above referred to in mind.

In our north country, snow-bound as it commonly is in winter, we have occasion to dread the spring freshets. If, following a season of heavy snowfall, spring comes on slowly, the snowdrifts melt away gradually, little trickles of water worm their way through culverts and sluice-ways, the ice in the brooks wears away by degrees, the heavy ice in the river becomes honeycombed with vertical lines of cleavage so that it grinds up readily, the spring floods are of the mildest character and, at the last, the ice goes out of the river quietly, while the black mallards are circling in quest of open water and the pussy-willow plumes are showing up. On the other hand, we occasionally have, instead of the slow oncoming of spring weather, a sudden downpour of warm rain, a big thaw, the while ditches and sluiceways are still frozen tight. Lacking drainage, the flats and low places are flooded, and there is Chicago, Illinois, to pay generally, if you understand what I mean.

Now, given a human system loaded with accumulated toxins, a large amount of potassium iodide will start elimination going, melting down infiltrations and freeing toxins with the result that our drainage system cannot handle the

overflow properly. It becomes badly clogged, therefore, our flats are flooded, our eyes and our noses run, and we say unlovely things about potassium iodide. We blame the iodide when we should blame our own lack of knowledge, or lack of judgment based upon our knowledge. The coryza can be controlled by atropine. In a way, I feel rather sorry for the therapeutic nihilist, that dyspeptic of the medical art, who has never mastered the art of prescribing effectively. I am rather sorry for him for I think he must make rather heavy going of it, traveling in low gear mostly, but I am not sufficiently sorry to have any desire to change places with him for a while.

I have said that potassium iodide is an eliminant. I use this term until I can think of one that better expresses my meaning. In lead neuritis, it is a common practice to give potassium iodide because it renders the insoluble lead salt or compound soluble, and enables the system to get rid of it. This "getting it out of one's system," to use the somewhat vulgar phrase, expresses the action of the iodide very well, if not elegantly, and it has the merit of being understandable.

With few exceptions, such as exposure to cold, trauma, extension of inflammation from neighboring parts, pressure as from a cervical rib which may cause a brachial neuritis, etc., neuritis in its various forms is due to nerve poisoning. This is indisputable. We have diabetic, diphtheritic, malarial, and other forms of neuritis due to toxins generated within the system. We have alcoholic, arsenical, mercurial, lead and other forms of neuritis, due to the ingestion of substances foreign to the system. In many of these neuritis cases, potassium iodide is our most effective agent, in combating the neuritis at least, and the reason seems obvious. Likewise, in many types of rheumatic or rheumatoid troubles, it is of great value and its use should be more extended. It is of much service in gonorrhoeal rheumatism, this in connection with fixation of the affected parts by plaster of paris splints or other appropriate treatment. In chronic syn-

ovitis of the knee joint, where the joint is filled with fluid, I have found no more effective remedy.

Cases of orchitis, or of epididymitis, which are slow in resolving under mere local applications and proper support, clear up rapidly when this local treatment is supplemented by the internal use of the iodide. In lumbago, and in certain forms of stiff neck and torticollis, after eliminating in so far as I am able the presence of some focal infection, I rely on this remedy largely to the exclusion of all others. We find many cases of obstinate skin eruptions, psoriasis for example, which will yield to massive doses of iodide. Leg ulcers of the various types, and this includes varicose ulcers as well, heal much more readily if suitable local treatment is combined with the internal use of the iodides.

While I was in charge of the orthopoedic department of a large hospital, we had a number of those chronic leg ulcers which had resisted all previous treatments. They all healed, and I got so cocky that I offered a box of most excellent cigars to any doctor who would send me a case of leg ulcer I could not heal. Many were sent, but I never had to pony up. I have luckily never yet had a case of leg ulcer that did not heal, save one chronic syphilitic who knew, better than any physician, how a leg ulcer should be treated and acted accordingly. He was unruly and rebellious, and ended up by going to a large hospital in the city. They treated him for a time and then amputated his leg. In most of these cases, I gave potassium iodide; in many of them mercury was added.

In certain cases of chronic and intractable diarrhoea, some of which gave a Wassermann positive, I could secure results from nothing but mercury and the iodides. The reader may draw his own conclusions. In ulcerative stomatitis of the chronic type, it has proved itself curative in manifold instances, and here I am not referring to mucous patches or syphilitic sore mouth.

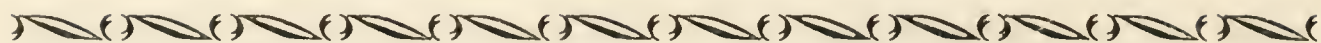
Patients frequently call upon us for the relief of head

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noises of an annoying nature. When examination of the auditory apparatus gives us no light on the cause of the trouble, I have frequently found that the iodides, sometimes in conjunction with the bromides, afford entire relief. Kelp, a seaweed containing iodine, is being used extensively in Bang's disease and pyorrhoea.

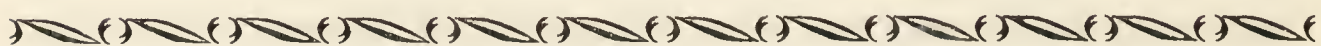
In a very large number of cases where I had patients under treatment for other troubles, such patients would return to me for more of the same medicine that cured their "sour stomach." In many instances, I had not even been aware that they had suffered from any gastric derangement. This naturally aroused my curiosity, and in cases of sour stomach and gaseous conditions attendant on hyperacidity, I began the use of the iodide, finding it of great service in many cases. We are naturally suspicious of cholelithiasis when a patient complains of these symptoms of chronic "heart-burn" and indigestion. How the iodide relieves this condition, I am unable to explain. The iodide acts on all the glandular system, the liver is our largest gland, normally containing about one-fifth of the total blood in the organism, which fact furnishes food for thought; here is where earth ends and cloudland begins. I am merely stating what I have repeatedly observed.

There are many other conditions in which I use the iodides with undoubted benefit, some of these being taken care of in other chapters. They say I am a crank on the subject. I have no intention of denying it. They also say everyone is a crank on some subject. The chief use of a crank is to start something. I prefer to be a crank on something that is at least worth while. I don't mind. Beyond all question the iodides are of exceeding value in a host of chronic disorders and obscure conditions which are not relieved by any other remedy at present known.



XXXI

THE BROMIDES



THE bromides should be considered as a group, since the action of the various salts is, in the main, the same. I have little sympathy with those pedants who take up pages dealing with the relative merits of sodium and potassium bromides or their combination with similar salts. Some of these writers seem to lack terminal facilities. I sometimes wonder if these long-distance runners would know what to do with a real idea if they ever caught up with it and grabbed it.

I find a widespread prejudice against the bromides. Most people and many doctors object to "dope" of any kind, an attitude which is highly commendable and above criticism. But why include the innocent with the guilty? The bromides are never habit-forming. In cases of epilepsy, and similar conditions of nervous unbalance, I have given them for years, continuously and without any ill-effect. When they were discontinued, my patient would merely draw a breath of relief, being glad that he was no longer required to take a medicine which had become tiresome. Habit-forming drugs produce a sense of exhilaration and well-being, which, in turn, is naturally followed by the inevitable reaction, since the higher we jump, the harder we hit when we return to solid fact.

The bromides have no such effect. They will control undue excitement and hilarity; they will likewise relieve many forms of nervous depression, due to over-sensitiveness of the nerve terminals or other prolonged irritations. They control reflex disturbances. In other words, they act like the balance-wheel of a watch, or the governor of an engine might be a better illustration. When the engine speeds up too fast,

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the balls on the governor are thrown wider apart by centrifugal force and automatically shut off to a proportionate extent the valve controlling the steam inlet. When the engine runs below the normal speed, the valve is opened wider to let in more steam. They are neither stimulant nor depressant in their action, but steadying and controlling, governing and stabilizing.

The bromides have no anodyne effect. They do not relieve pain. They promote rest, and are useful in many nervous disorders attended by insomnia, not by producing or inducing sleep but by permitting sleep. They affect chiefly the afferent nerves, blunting their peripheral endings and diminishing the reflex action emanating from these terminals. There are other theories as to their mode of action, but the one given is in accord with their known effect. If sleep is impossible, as frequently happens from mere surface irritability, where one cannot keep his legs still, and the contact of the bedclothes causes restlessness and constant change of position, the bromides will abolish such hyperaesthetic conditions, and normal sleep will follow. In the "fidgets," they are efficient, which means exactly the same thing. Even during the sleep of perfect health, it will be recalled that perfectly normal impulses emanating from sensory nerve terminals cause us to shift position occasionally without waking. This is a wise provision of nature. Were it otherwise, we would wake each morning with an incipient bedsore.

Another form of wakefulness, closely allied to this, is the type where we lie awake worrying over some little molehill of trouble which appears mountainous and insurmountable. In the morning, after a sound sleep, it assumes normal proportions. Here the bromides are indicated. Until I have seen at least one case of bromide habituation, I shall continue their use. Many cases of nervous depression of a temporary nature, frequently accompanied or followed by an attack of nervous polyuria, are promptly relieved by one full dose of the bromides.

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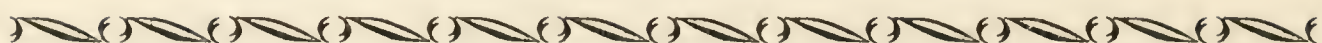
High blood pressure is occasionally of nervous origin and here bromide or luminal has a happy effect. In epilepsy, it is still our most servicable agent, luminal being a close second. In the diarrhoeal disturbances and fevers of dentition, it is of much value by controlling reflex nervous irritation. There are some cases where the ingestion of food is immediately followed by an inclination to go to stool, accompanied by the passage of loose bowel movements containing undigested food. Some of these cases are not due to any organic lesion, but to a reflex hyperactivity of the pylorus and a general hyperperistalsis. In such cases, the bromides are of use in controlling this over-excitability and restoring normal peristaltic action. It is of benefit also in the pyloric spasm of duodenal ulcer. Here it is essential that it be given well diluted.

The bromides have a wide range of usefulness. For instance, I am constantly meeting up with cases of "weak spells" usually attributed to "a bad heart," commonly accompanied by a feeling of intense depression referred to the cardiac area, a sensation of impending disaster, oftentimes with some palpitation or arrhythmia with depression of spirits and, occasionally, blank despondency. In such cases the opiates and cardiac tonics are not indicated, if you can exclude organic heart lesion, so much as the bromides, camphor, aromatic spirit of ammonia and the like. Forty-five to sixty grains of bromide of potassium or a lesser amount of the bromide of ammonium, given in a full glass of water at a single dose, is effective. I am not alluding here to cases of mental depression attended with melancholia, where the bromides are usually contraindicated, but to acute and temporary attacks such as described.

Where it seems desirable to keep a patient continuously under the influence of the bromides, from 30 to 35 grains per diem is about all the bromide of potassium which will be borne in adults without evidence of bromism. The dose of the sodium salt is approximately the same, that of the ammo-

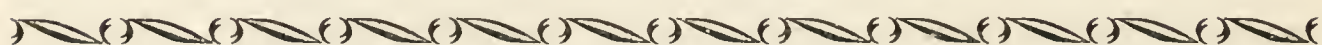
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nium salt 25 to 30 grains. In exact proportion to the activity of the organs of elimination, in young people the dosage of these salts is comparatively large, in the old and debilitated the dose should be correspondingly reduced to avoid the cumulative effect which will result in bromism. The triple bromides have one advantage when given steadily — they do not disturb the natural balance of the alkaline bases in the circulatory system to the extent that might possibly occur if only the one bromide salt were given for any great length of time. It is likewise to be remembered that a salt-free diet promotes the absorption and delays the elimination of such salts as the bromides and iodides of potassium or sodium.



XXXII

CONTAGIOUS DISEASES



WHEN a case of communicable disease occurs in a family, the question of the causation frequently arises, and it is not always easy to answer in the absence of any known exposure to infection. We always know that it did not arise spontaneously, but from a definite inoculation or infection with the specific germ of the disease in question. A setting hen may be used to hatch out duck eggs, but no chickens are ever so brought into the world; they are always ducklings.

Some years ago, a number of scarlet fever cases broke out simultaneously in two adjoining townships within my ride. It was obvious that there was some common source of infection, yet we were unable to locate it. The houses where these scarlatina cases occurred were widely separated, did not seem to have anything in common. The occupants did not attend the same church, did not go to the same school, had not been to any concert, show, public gathering of any kind at the same time and had not been visiting with each other. In some cases, the children who came down with the disease had not been away from home during the incubation period. It was only after they got out of quarantine and, having their interest aroused by our close questioning, began to compare notes, that it developed that a squaw living on a near-by Indian Reservation had, a week or so before the outbreak, sold a splint basket to each of these households. Further investigation disclosed that just at this time there had been several children in the Indian family ill with a fever, sore throat and a red rash. Anyone familiar with the conditions under which these Indians live, the way the children and adults are all together in the one small living-room,

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will have little doubt in his mind that these baskets were infected and carried the disease. What more natural than that the white children would also play with these baskets?

Likewise, the widow in some city tenement, doing piece-work on a sewing machine, may think it wiser not to say too much about an ailing child with a suspicious eruption, thus running the risk of being quarantined and if the handkerchiefs, so hemmed or embroidered, have not been sterilized, some child in Corey's Corners having a coryza may become infected by having its nose wiped with a brand-new handkerchief just out of the box on the merchant's shelf. It opens up a wide field of conjecture. Some of the mysterious ways of Providence of this kind, of which we occasionally hear, may be no mystery at all when the facts come to light. In the dark ages, demonology explained many of these occult visitations of plagues and tough luck in general, this view gradually losing ground down the centuries to the present twilight age. Many of our misfortunes, which we at present attribute to an inscrutable Providence, will eventually be found due to our own ignorance and our heedless violation of nature's laws; meanwhile, it is convenient to have a devout way of passing the buck.

It is, of course, easy and effective to say that the cause of any contagious disease is the specific bacillus or other germ of the infection in question but this is far from being a full and complete answer. It is the truth, it is nothing but the truth; it lacks one essential; it is not the whole truth. What, for instance, is the cause of a good crop of corn? Not merely the presence of seed corn possessed of sufficient vitality to germinate. There must be, in addition, proper soil, a soil that is moist but not too moist; this soil must be plowed, harrowed, prepared for planting, perhaps fertilized; a suitable latitude is required, for corn does not make a good crop save in the temperate zones; the right season, midwinter will not serve; proper weather conditions, not too cold, too wet or too extremely dry; judicious cultivation, protection from

thievish crows and blackbirds and from marauding cattle; harvesting at the proper time. The seed corn is essential, we grant you, but it may fall by the wayside or upon stony ground. Many factors enter into the problem; lacking any one of these the crop may be a failure. With all the factors favorable, the crop may increase thirty, sixty, yea an hundred fold.

A given disease may be abortive, a mild affection or infection, a serious malady or a fatal one, in like proportion. A little reflection along these lines will explain why we are not all victims of tuberculosis, for illustration. We have all been exposed repeatedly to the germ but the mere presence of the germ is insufficient. The question of immunity here enters but quite frequently it is the absence of some other essential factor which enables us to escape, rather than a true immunity.

Perhaps I am dumb ever since that sunstroke I may have had when too infantile to remember about it, but when I have been a little puzzled about these things I always think of the old vinegar barrel that stood in our back yard with the neck of an inverted bottle stuck in the bung-hole. This familiar fermentative process shows me in words of one syllable, as it were, what happens when a favorable culture medium under suitable conditions, if infected with the essential and specific germ, runs its course if not otherwise interfered with. My mentality is not too dull to understand the formation of alcohol and, by analogy, toxins; later the development of acetic acid and antitoxins, products which bring the fermentation to a close in that particular barrel and furnish a simple illustration why diseases like the exanthemata run a limited course instead of continuing indefinitely; the matter of immunity both natural and acquired begins to loom up definitely through my mental fog. I see with more clarity how a serum foreign to that particular cask may effectively control the fermentative process; I get light thrown on the beneficent substitutional effect of a vaccine

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and a glimmer of why and how a toxoid may be effective. I can even see clearly how the "mother of vinegar" taken from the barrel where fermentation has ended may be capable of starting up a precisely similar process when added to a fresh and non-immune medium. Like the vinegar itself, my ideas are racked off, clarified and stored away in an orderly fashion, for future use.

As regards the time when communicable diseases are the most highly infectious, writers are not in anything like full agreement. The universal law is, however, that most weeds spread chiefly at the time of going to seed. This rule is no more absolute than any other, yet it is the rule. Some spread by underground runners, others such as tumbleweeds, roll along the ground for long distances to spread their seeds elsewhere. Many seeds have wings and are wind-blown; others have hooked claws, while many have hard shells that resist digestion and such seeds may be found in bird-droppings. There are innumerable ways devised by nature to carry out her designs and she is a very designing lady, indeed, but I believe that the above rule will ultimately be found to hold good in most cases of communicable disease, viz., that they spread chiefly when the seeds are fully ripened.

Natural laws vary but they are, on the whole, pretty well correlated. Our major troubles are encountered when we endeavor to interpret them without sufficient knowledge. When Leverrier, from the behavior of Uranus, predicted the discovery of Neptune and hit it within less than one degree, it was not a chance shot in the outer darkness but a logical conclusion based on a universal law. What God has written in the rocks is just as good Scripture as the St. James Version. All seeming inconsistencies are due to errors in interpretation on the one hand or in translation and transmission on the other.

People often ask me if there is any danger of contracting measles, scarlet fever and kindred diseases, if they have had them once. In all honesty, I am obliged to tell them that they

may possibly have them again. If they show undue dread, following this statement, I explain to them that I have seen several two-headed calves, that we all know such things do occur but that no dairyman loses any sleep in anticipation of such happening.

In diphtheria, the comparative immunity of breast-fed babies has been fairly well established. That this is a true immunity I question. Adults seem to have a degree of immunity, yet in the old days when local treatment of diphtheritic throats was in vogue, many physicians contracted diphtheria through infected material being coughed in their eyes. Grown-ups have been taught to avoid obvious sources of infection. Young children swap chewing gum, bite each other's apples, hold the family lead pencil in their mouths, and suck the head of the older sister's doll.

On the other hand, the nursing baby, though breathing the same air as the other children, does not run the more serious risks of actual and direct inoculation. He is too young to use a lead pencil or thumb the same picture books, too immature to be a chicle devotee. He is fed at the breast to which the older ones no longer have access. He is unlikely to come in contact with the same cups and spoons since breast-fed children seldom require medicine. He is taken from his crib to be nursed, to be changed and (it is to be hoped) occasionally bathed, then put back; the young children are seldom allowed to play with him. The only thing he has in common with the others is the common air. His apparent immunity, like that of the adult, is less an immunity than an absence of liability to direct infection.

The trend of knowledge, painfully acquired during the past half-century, goes to show that communicable diseases are seldom spread through the atmosphere. Dried and powdered tuberculous sputum, membranes coughed into the eye, nasal discharges sprayed by sneezing are, of course, spread through the air, but this is not what I am referring to. Here we have actual contact of gross material, not an invisible,

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miasmatic, gaseous hypothetical poison. Actual contact, as with many diseases from itch to syphilis, hypodermic injections by insect bites as in yellow fever and malaria, things like these will eventually be found to be almost the sole direct modes of infection in the spread of communicable diseases. This view I have stoutly maintained for the past forty years and, though we had many a heated debate over it, events have to a very large extent justified my belief.

These points I am in my presumably feeble and senile way endeavoring to make: that the occurrence of most marked and definite diseases, whether communicable or not, is the result of a number of factors rather than one single agent, important or indispensable though that agent be; that, as we progress in enlightenment and in wisdom, it is to be hoped that we will rely more on clearer thinking, better logic and closer observation, in which case we will undoubtedly find that we bring most of these afflictions upon ourselves.

Uncle Eph says, "Eddication may teach a feller how to pronounce chassis an' coupé the way they should be, as I take it, an' understandin' will make clear to him *why* the blame thing goes, an' observation trains him to see what puts so many of them on the blink but it takes wisdom, a hull lot of it, to drive safely through the kind of a crowd we have here on Satiday nights."

As regards the legal aspect of contagious diseases, it is to be remembered that a ruling of the local Board of Health as applied to the community over which it has jurisdiction, is practically the equivalent of a State law if it does not conflict with the regulations of the State board. The latter is as near an absolute monarchy as can be found under a republican form of government. This is as it should be. In the control of epidemics, for instance, the proverb applies that the time to put out a conflagration is when a dipper of water will do it.

We have made progress since the day of Jenner in the prevention of contagious and infectious diseases, having now reached the age of the bacteriophage. We have nearly elim-

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inated diphtheria, smallpox, bubonic plague and Asiatic cholera. Typhoid, along with yellow fever and malaria, is under restraint. Tuberculosis is getting under measurable control and the prospects are that measles, scarlet fever, poliomyelitis and encephalitis lethargica, along with various other diseases, will become more amenable to treatment. Among the infections, "hospital" gangrene and "surgical" erysipelas no longer affright us. Tetanus can be prevented. The festering blights of the venereal diseases are gradually giving way under the sunlight of open-air methods. So long as they were hidden in the dark and verminous retreats which seem their natural habitat, but little could be done to check their ravages. If I were in Bellevue now, instead of some forty-nine years ago, the large tablet in the Medical Board room which I so frequently passed, with its long column of names of members of the house-staff who died in the discharge of duty, mostly from that dread disease, jail or typhus fever, might fill me with regret but would no longer give me the feeling that my own name might easily be the next engraved thereon. Despite technocracy, plutocracy and a host of other bogies which, like a jack-in-the-box, are held up to affright those of us who are swayed by emotion rather than by reason, this world is steadily showing definite improvement.

XXXIII

SMALLPOX

ONLY those of us who have had a wide experience with this disease are in a position to realize fully what a loathsome and horrible thing it may be. The patient verily hath no place to lay his head or, for that matter, any of the rest of his person and verily he smelleth like unto a hen-house on a warm April morn. If I had my way, I would dearly love to try the plan, at least in some communities I know, of not segregating smallpox patients but giving them their liberty. Such a course would quickly end the silly and inexcusable anti-vaccination crusade.

During a serious epidemic in a town which was “anti” on almost everything which was for its benefit, a well-known and highly respected resident had a very severe case of smallpox. A large proportion of the inhabitants had been insisting vociferously that they would much rather have smallpox than be vaccinated. Moreover, they believed it was only chicken-pox anyhow. With malice aforethought, the wisdom of the serpent or what you will, I persuaded the patient, when he was at his worst so far as appearance went, to do my bidding. I had his bed moved close to a window and, indirectly, through some whom I could trust, induced a number of the bolder spirits to look at him through the window, while he grinned at them like some hideous gargoyle. On the following day, when I visited that town, I found an entire change of sentiment and I did an unusual amount of vaccinating, by request.

The trouble with the anti-vaccinationist is that he does not know what he is talking about. He thinks he knows and he can make as much noise as if he really knew. To call him

an ass is to disparage donkeys in general. If we merely had the nerve to turn loose a few smallpox cases that were in full bloom, everyone would get vaccinated and the disease would come to an end. If perchance there were any who failed to accept such protection, the fool-killer would doubtless be delighted to take care of these exceptions. I will confess that I have never really tried this plan but I believe that I would experience an unholy joy in so doing.

Does vaccination protect and for how long? An experience I had a few years ago, while not conclusive, is quite interesting. In the section where I practice, approximately 90 per cent of the population, exclusive of those of preschool age, have at some time or other been vaccinated. At the time of which I speak, we had an outbreak of forty-three cases of smallpox. I defy anyone to go to this town and, without making inquiries, pick out forty-three unvaccinated people without making a miss, yet the smallpox did this unerringly. Moreover, a large proportion of those who escaped contracting the disease after they had been exposed to it, had not been vaccinated since childhood.

Any earnest seeker after truth or anyone having a shadow of doubt as to the safety and efficiency of vaccination against smallpox, should study the available statistics. The United States Public Health Service, for instance, has all the facts and records regarding vaccination in the Philippines and these are available to the public. The reports of Dr. Victor Heiser, Dr. Leonard Wood, Dr. John B. Long and others are informative to a degree. Colonel Henry L. Stimson published in the *Saturday Evening Post* of March 19, 1927, an article entitled "First-Hand Impressions of the Philippine Problem," which is not written in technical language and is particularly illuminating.

In a "Summary of the Vital Statistics of the U. S. Army During the World War" (see *The Military Surgeon* for August, 1922), Major Albert G. Love states that over four

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million men, including commissioned officers, were vaccinated against smallpox. Only one death was reported following this operation. This occurred in November, 1918, during the pandemic of influenza and broncho-pneumonia is given as a contributing cause. In the absence of a complete case-history, this one instance is open to a certain measure of doubt as to the chief factor in the fatal termination.

Some years ago the periodical *Life* was crusading against vaccination. One of our foremost writers pointed out that a study of the records before and after the American occupation of the Philippines would be illuminating and extremely interesting. "No doubt interesting, if true," was the editorial response, which was unworthy. Many a brilliant man is eccentric. Oh, thou anti-vaccinationist, one thing thou lackest, the will to admit the facts.

As regards the alleged horrors of vaccination, I can say that I have personally vaccinated many thousand cases (some 1700 during a single epidemic which I recall), and I have yet to see an arm among all these which has given me the least anxiety. True, I have seen a number of bad arms and very many bad scars, but since the vaccinating was not done by myself or in my presence, I am unable to state what methods were used and what precautions were taken to prevent infection with other organisms. Some of these infected arms were obviously cases of secondary infection due to accidentally knocking off the scab or to scratching, frequently during sleep.

There can be no question, even when vaccination is properly done, with good vaccine and strict asepsis, that in primary vaccinations there is frequently much swelling, not uncommonly brawny, much redness, a sensation of heat, itching and general discomfort but with little pain. It looks worse than it feels and some nervous people are unduly terrified. We are often more fearful of the shadow than of the substance; we are more afraid of the ghost than of the man himself though reason teach the contrary. A boil does not

look pretty, may be quite uncomfortable as well, but we do nothing but kid the proud possessor of it because we know it is not dangerous and we are all entirely familiar with boils.

In New York State we had compulsory vaccination at one time, particularly for school children. I believe that I am quite familiar with the facts when I state that the Antis did much lobbying and finally got a bill introduced in the Legislature, under the provisions of which compulsory vaccination could only be instituted in the presence of an epidemic and then only on the order of the Commissioner of Health. In the larger cities many of the health authorities are full-time officials and in fairly close touch with what is going on at the State Capitol. They promptly got busy and, failing to defeat this iniquitous bill, got cities of the first class exempted from its crippling provisions. About this time, the officials of cities of the second class got wise and had their cities likewise exempted. The health authorities in the smaller communities, not being in as close touch with legislative matters and working only as part-time officials, did not get in action soon enough. The result is that, in the Empire State with its exceedingly high record for efficiency in sanitation and in the prevention of disease, the smaller communities and the rural districts can lock the door only after an indefinite number of horses have been stolen. In other words, people outside the larger cities can have smallpox and be damned to them.

Since the advent of properly prepared bovine vaccine, the possibility of infection, through vaccination, by syphilis and tuberculosis has been eliminated. Some years ago I was called to one of the Canadian Provinces to see a young man who was in a most deplorable condition and considered past all human aid. The history was that his trouble was definitely and directly due to the typhoid and smallpox vaccinations which all the soldiers had received during the World War. The neighborhood was all worked up over the sorrowful outcome in this young army veteran. I looked him over thor-

oughly, sent his anxious relatives from the room on some excuse and bluntly asked him where he had met the girl who had "vaccinated" him.

"It was a girl in a French camp, but for Pete's sake, don't tell my folks."

I kept my own counsel and, fortunately, a course of salvarsan cleared him promptly so that he was soon in apparently excellent health and able to resume work. I merely gave out that there had been an error in diagnosis, that the vaccination had nothing to do with it, and this statement backed up by the reputed "miracle" of his recovery, quite satisfied the dear public and the furore subsided. But what a glorious opportunity our anti-vaccinationists missed by a narrow margin! How they would have reveled in all its horrible details! How zealously they would have broadcast this awful example throughout the land! How beautifully this would have bolstered up their doctrine! Contemplation of this makes me feel almost sorry for them.

I will have little to say regarding the cure of any of the exanthemata for the perfectly obvious reason that, in the main, "there ain't no such animal." In smallpox there is a time when the initial fever has subsided and a secondary recurrence of fever takes place coincident with the full development of the pustules. This febrile disturbance is likely due to secondary infection from the ever-present micro-organisms of the skin. Since the face and hands are commonly the seat of the largest number of pustules and, as Finsen long ago pointed out, light seems to have a deleterious effect causing much pitting and scarring, any measure which will mitigate this is of value.

For this purpose the patient should be kept in a dark room and a fairly strong solution of nitrate of silver should be painted over these exposed surfaces. This forms an impermeable film of albuminate of silver, shutting out the light to a great extent and exerting a marked germicidal action on the pus organisms. In this way it prevents pitting and scarring to a

great degree. It turns the skin jet black but this is only temporary and, since the victim of smallpox receives few visitors, is of minor importance so long as it avoids permanent disfigurement.

I have been through many epidemics of smallpox, but in this book I have purposely omitted all reference to the differential diagnosis between smallpox and its first cousin, chicken-pox. To safely distinguish between toadstools and mushrooms requires field work under expert tutelage rather than the casual perusal of a monograph on the subject. We can leave the diagnosis to the physician in charge or to the Board of Health experts if need be. The resemblance between smallpox and chicken-pox is only superficial. It is more than a difference in degree, like the Ork on his globular island when —

“He batters his spoon on the edge of his porringer,
And his nose grows the shade of an orange but oranger.”

XXXIV

SCARLET FEVER

SCARLET FEVER is sometimes so mild that it takes a composite picture of many cases before one can be quite sure of his diagnosis. One case will have a suspicious-looking throat and perhaps a strawberry tongue, another will have a fairly definite rash, but no other well-defined symptoms, a third will show definite desquamation and perhaps ear complications, a fourth will give little history of any serious illness, but will develop scarlatinal dropsy some little time after a few days' indisposition, the whole ensemble showing a definite and unmistakable picture when grouped but individually open to doubt. On the other hand, scarlet fever can be a very serious malady with a high mortality.

Of the various complications of scarlet fever, the one which seems to me to be the most feared by many is scarlatinal nephritis with dropsy. So far, I have had no special occasion to dread this sequel. The remedy is to sweat these cases with the utmost vigor. For this purpose, I am in the habit of using hot vapor baths. I use from three to five bricks heated in the oven, then put to soak in boiling water, taken out, wrapped in dry flannels and placed about the patient who is covered well to the chin with blankets, arms under, and diaphoresis maintained for two hours, the temperature being taken from time to time to forestall a possible but wholly improbable hyperpyrexia. Three sweats of this kind on three successive days is, as a rule, all that is required beyond a milk diet.

On one occasion, when I had gotten these preparations nearly complete, the patient's older sister returned from school. She said, "Georgie, what have you got those bricks in the hot water for?"

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The six-year old patient said, "The Doctor is here and he says I've got the dropsy. First, I've got to swaller them five bricks and then I've got to drink that whole tubful of hot water."

"But how can you ever do it, Georgie?"

"I don't know how I ever kin but the Doctor says I must, so I'll have to get 'em down somehow," this young Ananias gravely asserted.

In certain epidemics of severe scarlet fever, we get a brawny swelling which resembles that of Ludwig's angina. Now, in the latter, which is always a serious affection, I have never seen good results save by the use of ice which will control the swelling and afford opportunity to make a thorough search for the focal infection which is commonly at the bottom of the trouble. I have seen a number of these cases die in the hospitals despite free multiple incisions, drainage, tracheotomy to relieve impending suffocation, etc., but the cases in which I used ice all recovered. The brawny swelling of the scarlatina cases referred to seems quite similar and is a very grave complication. I have never used ice in these cases, and do not know whether it would work for good or ill, the reason being that in one of my early cases of scarlatinal nephritis, I found this enormously swollen throat and when I gave my patient a sweat for the nephritis, the throat swelling all subsided, rapidly melting away like a snowdrift in the April sun. Being able to take a hint if it has ample knee-action back of it, I subsequently treated all such cases by copious diaphoresis, and so far with only the happiest results. I have never had occasion to try the ice.

In many cases, there is more or less swelling in the lymph glands of the neck due to a serious infection of the nasal passages and throat, and these cases commonly develop suppurative ear troubles leading to deafness, if nothing worse. Aside from the prevention of this sort of trouble by enucleation of tonsils and adenoids in early life, the only treatment which I have reason to consider valuable is that by irrigation.

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I use, as a rule, normal saline, about blood warm, every two hours, by means of a fountain syringe. The child lies on its side, the bag of the syringe is elevated not over three feet, and the fluid introduced in the upper nostril escapes by the lower, the mouth being kept wide open which prevents swallowing. If the throat is in bad shape, this should be irrigated as well. If gentleness is used, especially the first time the irrigation is employed, it affords them such comfort and relief that they seem always eager and willing to have it used again. It seems to me that something in this line of treatment is always indicated in this class of scarlet fever cases. We occasionally have a double infection, diphtheria not infrequently complicating the scarlet fever. In such cases I have not hesitated to give diphtheria antitoxin and have been fully satisfied with the results.

Since the Dick test has come into use, we have had no epidemic of scarlet fever, either here or in the location where I practice in Florida. For this reason I will make no comment on either the test or the serum treatment save that it seems to be of value. A few mild cases prove nothing and I feel a bit shy.

Uncle Eph says, "I was kind of a bashful chap when I was a youngster an' one night I was at some doings an' everybody happened to stop talking an' I felt like it was up to me to say something, so I says to the girl that was giving the party, 'Miss-er, Miss Edith, h-how's your mother? Not that I give a dang but just to m-make talk,' an' everybody haw-hawed so I shut up after that."

XXXV

MEASLES

MEASLES occurs rather more frequently than any of the other exanthematous diseases, and probably it is the most contagious disease known with the exception of epidemic influenza. Few people escape having measles at some period of their lives. I have to a large extent lost faith in quarantine measures for its control, not because quarantine measures are ineffective but on account of a disillusioning experience.

I have been health officer in a consolidated district for over forty-eight years. I persuaded the Board of Health to pass a by-law making measles and scarlet fever quarantinable diseases. This was in 1891, when such measures had not come into use to any extent in these troubles. For the ensuing twenty-three years, I quarantined carefully every case of measles appearing in my jurisdiction, and we had no epidemic of the disease. Meanwhile, a large number of young people grew up without having been brought in contact with the affection. Measles then broke out in two French-Canadian families with the customary swarm of children in each. No physician was in attendance, and the children not ill with the disease were sent to school as usual. The result was that the main public school and many of the smaller schools were presently closed. The malady spread like wild-fire throughout the town, so many coming down with the disease, and so many houses being under quarantine that we were unable to handle the situation. Had the health authorities known of the early cases, this serious epidemic could have been averted; as it was, we were powerless, and I must say that I would much prefer to have an occasional minor epidemic than to go through what I did during that major one.

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This is no argument against quarantining measles, but my faith in such measures received a shock from which it has not yet fully recovered. I prefer to have my measles retail rather than wholesale.

Unless measles is known to be present in a community, the early diagnosis of the disease is not easy and many errors have been made, since the bone-ache, coryza, bronchitis and other early symptoms may be readily mistaken for diseases like influenza, for instance. Unlike scarlet fever, the eruption seldom appears before the fourth day following the catarrhal and febrile disturbance ushering in the disease. In many instances, the rash is delayed to the fifth or sixth day when it begins to show about the roots of the hair or behind the ears. Koplik's spots appear in the mouth prior to the skin eruption, and this is frequently of great assistance if suspicion is aroused and the spots are looked for.

It is a common practice to "bring out the rash" by the use of external heat. This is not always a safe procedure and I doubt if it does any good. Admittedly it will often render the rash visible by bringing the blood to the surface but one can lay a piece of paper over a coin and, by rubbing it with the butt end of a lead pencil, bring out a picture of the coin. It is a childish pastime, however; financially you are no further ahead.

The peculiar croupy tone of the cough, the measly odor and the eye irritation should help in the early diagnosis, and in many cases we need all the help available. The cough is undoubtedly due to the eruption appearing in the air passages, and is little benefited by the usual cough remedies which too frequently merely upset the stomach. A few doses of Dover's powder seem to me to be as efficient for this purpose as anything, and it has, over and beyond this, the effect of allaying the bronchial irritation, a marked tendency to bring the blood to the surface and promote diaphoresis, all of which is desirable in measles. Almost all of the fatal cases

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of measles die as the result of broncho-pneumonia, and every effort should be made to avoid this complication.

Mild counter-irritation all over the chest in the early stages, and more vigorous measures in the late stages, if broncho-pneumonia has actually developed, seem to me to be the most efficient measures and the vesication produced by croton oil has, I fully believe, saved many cases of broncho-pneumonia, or as I prefer to call it here, measles-pneumonia, that were apparently hopeless. I use $\frac{1}{2}$ ounce of camphor, one ounce of croton oil and enough kerosene to make a 4 oz. mixture, rubbing this well in every three hours until I get the characteristic action of the croton oil. Occasionally I have been compelled to use straight croton oil.

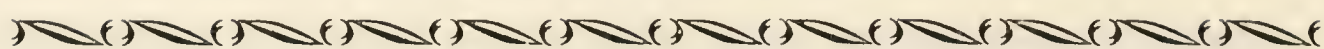
The next in frequency of the serious measles complications, so far as my experience goes, is gastro-enteritis. It is extremely likely that, in such cases, the eruption occurs in the mucous membrane of the intestinal tract. The number of cases of this sort that have come under my personal observation is so limited that I do not feel like giving any opinion on the matter in question. I treated my cases on general principles, giving a full dose of castor oil and following this with opiates.

For a number of years we have had no measles here and I have had no opportunity to acquire any personal experience either with parental blood or with the serum of convalescent cases.

In connection with measles, I am reminded that many years ago an article appeared in one of our medical journals entitled, "Does a Sick Man Ever Sneeze?" claiming that this symptom occurred only in well people. Dozens of letters followed, corroborating this. Another article was published claiming that yawning was an invariable sign of recovery. Again the doctors tripped over themselves in the rush to prove that they had been equally observant. Wearily I asked the editor if any of his readers had ever had measles and if any had seen a case of post-partum hemorrhage that had

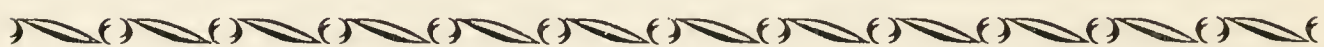
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reached the yawning stage. No more letters appeared for the reason that measles is almost invariably accompanied by sneezing, and in the hemorrhage cases yawning comes on just prior to death.



XXXVI

DIPHTHERIA



SO MUCH has been written concerning diphtheria that I will not weary the reader with anything further than a few general observations based on a wide experience which includes the pre-antitoxin days. When I graduated in medicine there were a thousand and one cures. A glance at the therapeutic index of some of the earlier editions of the United States or National Dispensatories will confirm this statement. Today, there is but one remedy, antitoxin. Among the popular remedies then in vogue were the insufflation of sulphur, and the giving of kerosene in teaspoonful doses. A gravy, made by baking live green frogs with butter in a covered roaster, was an infallible remedy with one local practitioner whom I knew well. Another remedy, which was highly recommended, was a syrup made from three eggshells, a pinch of borax, a pound of loaf sugar, a quart of soft water and the inside sole of an old shoe, boiled together for one hour and then strained. Having seen this concoction in use, I am of the opinion that no self-respecting Klebs-Löffler bacillus would remain long in its immediate vicinity. Remedies approved by the regular profession were little better than some of these mentioned.

In the early days of which I speak, despite the deadly fear of the disease, public funerals of those dying of it were the rule and quarantine measures were not systematically adopted, or were carried out in a desultory fashion, not so much from lack of effort on the part of the physicians as because the people had not yet been trained to obey the mandates of the health officials. Membranous croup, croupous laryngitis, was a common and fatal disease. We hear little of it today.

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At a meeting of the Academy of Medicine in New York in 1889 or 1890, Dr. Joseph E. Winters advocated the theory that membranous croup was simply laryngeal diphtheria. There were many eminent authorities present, and they were seemingly all opposed to his heretical belief; they did not hesitate to tell him so, denouncing his views as unsound and dangerous. The worthy doctor apologized for his unorthodoxy, admitted his fallibility and his lack of knowledge, asking humbly that he be enlightened in order that he might avoid such an error in the future. I thought that I caught a little glint of amusement in his eye, and my belief was confirmed when they stepped into the trap and fell to disputing with each other over the differential diagnosis. I left the meeting fully convinced that it was useless for me to try to tell these conditions apart when the experts tangled themselves up so lamentably. All great reformers were necessarily heretics before the reforms became established and, eventually, this term is often a title of honor. Dr. Winters was in some respects a heretic, but he had a genial and kindly humor and was a master of strategy in debate.

I have seen these cases of so-called membranous croup almost invariably yield to a full dose of antitoxin. Many of them showed no nasal discharge, no trace of albumin in the urine, no bad odor to the breath, no swelling in the neck glands, had no fever and nothing in the fauces that we could *see* that would indicate infection. Though these cases would not respond to any ordinary treatment, quite frequently the attending physician would not consent to the use of antitoxin until it became obvious that he must decide between this and intubation or tracheotomy. Throat cultures were usually negative in these cases but in a number of instances, following the antitoxin, membranous casts were coughed up which, on examination, showed the characteristic bacillus.

For many years I have been strongly of the opinion that an attack of diphtheria confers a large measure of immunity.

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to subsequent attacks. In several instances where a second outbreak of the disease had occurred in a large family, those who had suffered from the disease in the prior outbreak were permitted to mingle freely, without any direct immunization, with those who were afflicted with the disease. In no such case did infection occur. If a previous attack of diphtheria has no immunizing power for any length of time, I am at a loss to explain the immunizing action of toxin-antitoxin or toxoid. It is true that we are not in any position as yet to state with any degree of assurance just how long this immunization in either case may be effective. However, I believe that the most of the cases where diphtheria seemingly occurs the second time will be found open to suspicion as to the diagnosis. In the older days, in the absence of throat cultures, there were other exudates the character of which might readily be misinterpreted.

One Pete Lafrance came home late one night and fell flat on the side porch. His wife came to the door and asked, "What's de troub', Pete?"

"I t'ink — hic — I got de diptery, Melissa."

Those of us who treated diphtheria in the pre-antitoxin period are in a position to state with the utmost confidence that antitoxin is never a cause of diphtheritic paralysis. It has been repeatedly asserted, and at times it would almost seem true, that diphtheritic paralysis is now more frequently encountered than formerly, that is, in proportion to the number of cases. It must be borne in mind that this complication is usually, if not always, a late manifestation of the severe cases. Before antitoxin superseded the methods then in vogue, these virulent cases were usually safely buried and the funeral chairs returned to the mortuary establishment before paralysis had time to develop.

Those of the present generation can have but little conception of the havoc wrought by this disease in the preantitoxin days. While I was with Dr. Gillis in the early '80's we had an epidemic of diphtheria. Out of one family of

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eight children, seven died. In 1897 we began giving antitoxin. It was of poor quality, expensive, but we were desperate and tried it. I have a vial of the first I ever saw, in my office at the present writing. About a month ago I saw two women, young girls at the time antitoxin came into use and these two were the first cases in which it was used in our locality. I watched them carefully because they were fine girls and because I was exceedingly anxious to note the effect. A big blizzard was on and I started back home, a distance of some three miles, about 11 P.M. In the raging storm I found the roads blocked. I took down a lot of rail fences and lost my bearings a number of times, but after a desperate struggle, reached home at last. On the following morning, Dr. Merrick, a dentist and an uncle of these girls, living in the village, called me up and asked me if I would go with him to see his nieces providing he sent a team and some men ahead to break out the roads and he drove me up. I accepted his offer but did not tell him until our return that I had gone up in the middle of the night, alone, during the worst of the storm. Why bring that up and spoil a good thing.

I did a number of tracheotomies for laryngeal diphtherias in the pre-antitoxin days; one I recall was late at night, on a baby. The only light I had was a kerosene hand lamp with a piece of paper pasted around the broken chimney to keep it together and a farmer's wife to hold the light. The operations I did were satisfactory in every way but tracheotomy does not stop diphtheria; the cases were commonly among the destitute and the absence of nurses capable of maintaining a moist atmosphere made my final results rather discouraging so I ordered an intubation set. I think I did a series of intubations which were the first in our section.

At the present time, if we meet with a severe and neglected case, we can clear the throat and cure the diphtheritic infection, but, if the system is already overwhelmed with the toxins, paralysis is still likely to occur. Antitoxin will prevent the paralysis absolutely if given early and in sufficient

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dose. I say in sufficient single dose rather than in repeated doses. I cannot whole-heartedly approve of the attitude of the young lady who told her veterinary surgeon to cut off her little dog's tail an inch at a time to save the little dear's feelings. Wholly aside from this viewpoint, I always feel that my judgment was wrong in the first place if I have to give a second dose. Personally, I never hesitate to give as an initial dose all that I consider essential to effect a cure. It avoids delay, lessens the liability to complications, including anaphylaxis, and I have never seen it do the slightest harm.

One day I was called up to Bombay and found a girl with a serious case of the disease. The grandmother had died two days previously from "quinsy" and a throng of people, many of them from various other counties, had gathered for the funeral service. At that time we had a small supply of commercial antitoxin and that furnished by the State was restricted very rigidly to paupers only. Quietly I got all I had in stock and all that the health officer of Bombay possessed, and armed with this heterogeneous supply, we corralled the whole bunch and gave them each an immunizing dose. Then I wrote to the State Board of Health telling them how we had overstepped and tendering our resignations. They promptly replied saying that they had never known of a better instance of its use and that we had beyond doubt headed off a widespread epidemic.

Some years later two young children in the township of Dundee, Canada, were taken with the disease. They were unable to buy antitoxin and it was not furnished by the Provincial authorities at that time. I used the State antitoxin and wrote the State Board that I would pay for it myself. They approved of my action, however, and published my letter in the next issue of the *Health News*. It was copied by various papers from Maine to California. It seems rules are made to be broken.

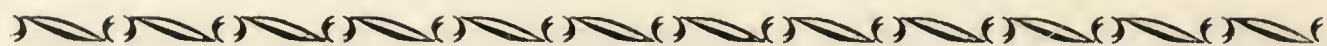
The Schick test and the use of diphtheria toxoid are to be highly commended. Such immunization is practically

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painless, causes little or no reaction, and after an extensive experience, has proven entirely satisfactory to me. It is supposed to take about a month before it is fully effective, hence the following rule would seem logical. For diphtheria, a full dose of antitoxin. For immunizing contacts, a small dose of antitoxin. For general immunization, where the element of time does not enter, diphtheria toxoid. When in doubt, try the Schick test.

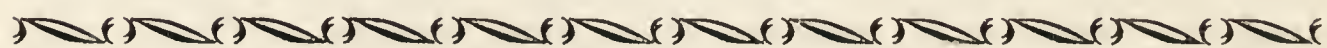
Diphtheria carriers should have all adenoidal and tonsillar tissues carefully enucleated. No other measures which I have employed have been of much service. The ring of Waldeyer should be thoroughly cleared.

As to the dangers of giving toxoid, or for that matter, large doses of antitoxin, it reminds me of what was said long ago, that there is danger in exposure to cold, in drafts, in lack of ventilation, in breathing a germ-laden air, but there is still more danger in holding one's breath altogether.



XXXVII

TYPHOID FEVER



I HAVE frequently been called in consultation over some typhoid case, in say the third week of the fever, to find the patient lying on his back, to a greater or less extent oblivious of his surroundings, fever-flushed, emaciated to a degree, with cracked lips, dry tongue, sordes on his teeth, a drum-like, distended and tympanitic abdomen. Diarrhoea is usually present; he has a muttering delirium, a small pulse, scanty urine, twitching muscles, possibly flexed and rigid arms and a retracted neck, mayhap carphologia and coma-vigil. "Such a condition," some authors say, "is fitly termed the typhoid state."

The attending physician seems to take it for granted that this condition is a necessary concomitant of a certain proportion of typhoid cases, and the textbooks bear him out in this belief. In fact, he not uncommonly feels proud of having such a severe and "typical" case of typhoid, as the Scotchman who swore with vigor and fluency in the presence of the bishop. The bishop said to him, "Man! man! Where did you learn to use such language?"

"Hoot! Mon!" replied the Scot. "You caan't *larn* it; 'tis a *gift*!"

It seems to me that the so-called "typhoid state" is not an essential phase of the disease but the logical result of an inefficient line of treatment; of a failure to recognize and appreciate the principles which should obtain, at least until such time as we shall fully work out a specific serotherapy which will enable us to handle the disease in a wholly different way, a problem for which we all hope there will be a satisfactory solution in the immediate future.

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I maintain that a patient should not be allowed to get into the condition referred to. If, however, it occurs, it has been my custom in these cases to see that the patient gets without delay an ounce of Epsom salt or two or three ounces of castor oil, usually to the horror and unqualified disapproval of the nurse in charge, and I not infrequently have to reassure the attending physician by assuming all responsibility for the effect of such a dose. When, instead of the alarming prostration which he feels sure will follow the administration of such a heroic dose to a patient in this desperately depressed state, he finds his patient at his next visit phenomenally improved, he arrives, usually with commendable promptness, at one of two decisions. One is that he has had some light thrown upon the immediate cause of "the typhoid state." The other may be that he has merely witnessed another remarkable example of fool luck. Which of these diametrically opposed conclusions he arrives at is largely a matter of individual temperament. This we cannot presume to alter and therefore must abide in patience and such serenity as we may possess. If the Lord intended us all to see things in exactly the same way, He would doubtless have made us all five feet nine inches in height, and Scotch-Irish Presbyterians — like myself. He doesn't seem to have done so.

I think we are all prepared to admit that the two salient features of the vast majority of cases are the continued fever and the abdominal symptoms, while all others are, relatively speaking, of secondary or minor importance. From this clinical standpoint we may, for the sake of clarity, class all the various symptoms, multitudinous as they are, into a few groups.

The fever lasts on an average twenty-eight days. Some cases, as we all know, are abortive and run a much shorter course. On the other hand, some run a much longer time. I had one case who had a continuously high fever for sixty-five days without remission, before she finally recovered. There was no question of the exact duration of the fever,

or of the diagnosis, since I had been treating several other cases of the disease in the same household when she contracted it. Another case ran fifty-seven days without sign of break. Still another case had the usual twenty-eight days of fever, a week of apparent convalescence, a relapse of three weeks' duration, another interval of a week, a two weeks' run of fever, and finally a recurrence of one week, after which, much to my relief, he stayed well. He was getting on my nerves. This was before the days of agglutination reactions and the other tests for which reason a possible undulant fever can not be ruled out, but, aside from the peculiarity of the relapses, it had the symptoms of a regular typhoid.

With a fever of such duration as typhoid, we should expect to find a marked shrinkage in the body weight, dry lips, fissured tongue, sordes on teeth, urine scanty and of high specific gravity, a small pulse and other evidences of dehydration from the long continued high temperature. This is one group of symptoms.

With the primary focus of the infection located in the digestive tract and the chief culture tube some thirty odd feet in length, loaded with media obviously favorable to the rapid growth of immense colonies of germs, we should expect to encounter another group of symptoms, disturbances of digestion, constipation or diarrhoea, tympanites, meteorism, abdominal distention and, under this head as a result of the accompanying ulceration, at times those dreaded complications, hemorrhage and, possibly, perforation.

It seems obvious that a third group of symptoms, such as headache, photophobia, deafness, and later, hebetude, stupor, muscular rigidity, the low delirium, carphologia and coma-vigil are the direct and logical result of absorption of toxins and consequent poisoning of the nerve centers. In fact, it is reasonable to assume that the rise in temperature is due to disturbance of the heat center of like character.

The various complications involving other organs can reasonably be attributed to the localization of other and

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secondary foci at points more or less distant from the primary focus, giving rise to pneumonia, parotitis, periostitis, typhoid leg and the like.

To recapitulate, we have those symptoms due chiefly to the high temperature extending over a long period, the evidences of a seething fermentative process in the intestinal sewer, those attributable to an intoxication of the nervous system, and those due to secondary invasion of other organs and tissues.

Since the treatment of typhoid is as yet essentially symptomatic, we may deal with these symptom groups in the order named, and the indications seem clear and logical. The treatment should be in the main eliminative. This is accomplished by active purgation together with the administration of large quantities of fluids. The emaciation, the drying up of the body fluids, the scanty secretions, can be successfully combated only by the ingestion of large amounts of fluids, wherefore, if for no other reason, the use of liquid nourishment should be insisted on, in order to counteract the desiccation of prolonged high temperature. As a matter of fact, in view of the very large percentage of water in the body as a whole, the loss of weight is akin to that of the dried apple, not necessarily a loss of tissue, and when liquids are given in sufficient quantity, together with sufficient nourishment, it is astonishing how little loss of weight occurs.

I am in the habit of giving to adults from two to three litres of water in the twenty-four hours. These patients are apathetic; they do not like to be disturbed, and often object to so much water, but I assure them they are lucky that they don't have to take something that tastes worse. If I find at any time that the urine is of high specific gravity, or scanty, or the tongue shows the slightest indication of dryness, I order more water and yet more, until the tongue moistens and the urine is plentiful. Water will not hurt them. It will *not* derange digestion by diluting the gastric fluids. Any reasonable amount is safe — if they can swim. The way to

put out fire is with water, and plenty of it. The way to control fever is to use water. And the place to turn on the hose is not on the surface but where the fire is. Not on the rose rash, but on Peyer's patches.

The second indication is elimination, the clearing of the intestinal tract of the vast colonies of germs. Not once, by giving an initial dose of calomel, as so many writers recommend, but daily. There seems to be a wide-spread fear throughout the profession in regard to giving purgatives in typhoid. This I believe to be utterly without warrant. My belief is based upon a long and extensive experience in giving many different purgatives to all sorts and conditions of typhoid cases. I have been in the habit of insisting on free purgation every day *during the height of fever*, to the extent of three or four movements per diem if not more, together with a sufficiency of water by the mouth.

At first, I followed this method in fear and trembling, but I have outgrown this and the bogie-man no longer affrights me. On the other hand, free purgation without the giving of adequate quantities of water to replace the fluids evacuated will only assist the desiccating process already inaugurated by the continuous fever.

In my judgment, the worst thing that the practitioner of medicine can do for any case of typhoid flux, or for that matter, for any case of acute dysentery or diarrhoea, is to give an astringent or any similar remedy to "check" the discharge. With free purgation your typhoid diarrhoea ceases. You cannot get more than two pints of peas out of a quart measure, neither can you get intoxicated from an empty flask. You cannot have a typhoid diarrhoea when the intestinal tube is thoroughly cleared, nor much intestinal toxæmia from an empty bowel. In fact, the chief trouble I have in this line is in getting the bowels to move every day with sufficient freedom from any reasonable dose of purgatives, which is what you would naturally expect as the result of repeated catharsis.

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Moreover, with the clearing of the digestive tract, you do more than clear out the fecal debris and masses of bacteria. You carry out a lot of unabsorbed toxins. In addition to this, you start a serous flow from the vessels and lymphatics, so abundant in this region, into the bowel, carrying with it much of those poisons previously absorbed and diluting the remaining poisons in the blood, lessening their concentration, by means of the water taken into the stomach.

As regards the cathartics to be used, I have little to say. I am advocating certain general principles, not the use of any specific agents. I have used castor oil and salts extensively, compound licorice powder, mineral waters and numerous other purgatives not drastic in nature, with the utmost freedom. It is results I am after and the purgative is merely the means to an end. The dose which might act as a brisk cathartic to a person in health may be utterly ineffective when given to him during an attack of some serious malady. A dozen small movements may be no indication that your cathartic has acted thoroughly, but two or three voluminous and malodorous stools constitute much better evidence. Err if necessary on the side of generosity (I am not speaking here of irritant cathartics like croton oil), and give dose enough. If an ounce of castor oil were proven to be, in a given case, an ample dose to clear out the bowels, and you in excess of zeal should give three ounces, there need be no cause for apprehension. You will merely find the unnecessary two ounces on the top of the last stool.

Give free catharsis, and the fever subsides to a large extent, while the symptoms of intestinal toxemia referred to are promptly ameliorated. With a fever of 102° or 103° F., I order a brisk cathartic, more purgatives, more water. For many years, I have not found it necessary to resort to external bathing in these cases, once I had the bowels thoroughly evacuated and washed, save as a matter of comfort and cleanliness or to induce sleep. As we are all aware, in private practice the Brand baths are difficult to carry out, particularly in

the absence of a trained nurse, and are uncomfortable to the patient who often becomes rebellious. I have yet to see a case of typhoid in which, after the patient had been under treatment twenty-four hours, the tub bath seemed indicated. Nor have I seen a case of hyperpyrexia from this or any other cause in which I could not reduce the temperature to any desired degree by the sponge bath alone, properly administered. I say properly administered for I believe the failure to reduce temperature more than a degree or two by sponging is due to faulty technic, due to a failure to appreciate the physical law which controls its action. The tub bath lowers the temperature by direct cooling and abstraction of heat through contact. This occurs to a very limited extent also in cold sponging. Personally, I do not use cold sponging in these cases, but warm sponging.

In hot climates, in the absence of ice, it is a common custom to suspend porous jars containing drinking water in some breezy place under the shade of a tree. It is a well-known physical law that water during evaporation absorbs a large amount of heat which in the vaporous form becomes latent and the surface of the porous jar being constantly moist, evaporation takes place rapidly and the water in the jar becomes cool. A similar process occurs when you exercise sufficiently to induce perspiration. This is Nature's way of reducing excessive body heat. If this principle is definitely borne in mind in giving a sponge bath, if the entire body of the patient is freely exposed to the air and, by energetic work on the part of the attendant, the entire surface is kept thoroughly moistened so that in the presence of the high fever rapid evaporation takes place, I have never failed to secure all the reduction in temperature I could desire, and for this purpose warm water is practically as effectual as cold, while far more agreeable to the patient.

The third general indication for treatment is to promote intestinal antisepsis. Personally, I would not claim that we can secure anything like asepsis of the entire alimentary

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canal by any safe means as yet known, and I believe that the use of antiseptics in these cases is practically of little avail so long as the bowels are distended with large accumulations of decomposing food wherein the bacillus of Eberth and other organisms find an excellent culture medium, free from disturbance, at exactly the proper temperature for their incubation.

I *do* believe that, given repeated purgation, plenty of diluents, intestinal lavage, given thorough and repeated washing and rinsing of the bowel, the use of reasonable doses of intestinal antiseptics will inhibit the growth of the remaining bacilli and accomplish a practical if not absolute sterilization of the tract, precisely as we do in infected surgical lesions elsewhere, in this way preventing to a large extent secondary invasions of other regions. Here we are following general surgical measures in that the most efficient way known of preventing secondary infections is to cleanse and disinfect as best we may the primary focus. Destroy the main camp and trust to Nature's forces to pick up the skirmishers.

It may be of interest to note that, according to Herodotus, Cyrus the Great, some 550 years before the birth of our Saviour, carried with him on his marches boiled water in vessels of silver, mule-drawn on four-wheeled vehicles, this for the use of his own table. Cyrus was great, all right. The ancients doubtless knew a few things which were later forgotten or old Cy may have been ahead of his time; like the Irishman who got the sex of the baby down fine on the second guess; either supposition has a measure of justification.

One afternoon an elderly and temperamental maiden lady demanded that I forbid the boys swimming in a pool in the Salmon River some distance above her house, this on the ground that it polluted the water. I reminded her that the river water had been condemned for internal use some years before. She insisted that the practice rendered the water unfit for any purpose and that it was my duty to put an end

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to it. In my best judicial manner I told her that I was health officer for the entire community, not for any one individual, that I was compelled to look at both sides of the question, that, while I could appreciate her point of view, I must also take into consideration the improved sanitary condition of the boys before arriving at a decision.

Bedsore are not infrequent in this disease if proper precautions are not taken. The inflated air-cushion, known as an invalid ring, is uncomfortable and unsatisfactory. A much better form is what is known to the trade as a square reeded chair cushion. This must not be fully inflated, but be soft enough to allow the buttocks to sink through it to the mattress. In this way it gives a firm and steady support while, at the same time, the projecting parts are relieved of any undue pressure. In the absence of one of these, I have frequently made use of a lambskin, tanned with the full fleece on. The wool is springy and has no tendency to mat up in lumps. In typhoid cases it is necessary to protect such a fleece from contamination by nursery sheeting or similar material.

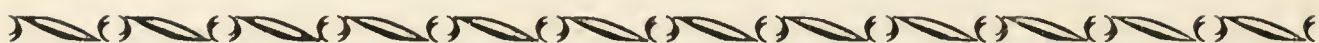
I have merely mentioned the use of typhoid vaccine. I take it for granted that no intelligent internist, at the present time, neglects to immunize contacts. All the cases which have come under my observation during the past half-century have, with few exceptions, been definitely traced to contaminated water. The exceptions were occasional imported cases where we could not determine the source of the infection with any certainty and a few that were traced directly to carriers.

There can be no doubt as to the presence of a large number of unrecognized carriers and we cannot hope to eliminate typhoid until such time as these are located and appropriate measures instituted. Much excellent work has been done along this line but much still remains undone.

I have no specific treatment for typhoid and have merely outlined the general principles which I believe should govern since they seem reasonable and logical. To quote from a

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famous document: "We hold these truths to be self-evident." Nor am I offering any statistics to prove my contentions. When I run across an occasional article in which the writer states that he has had 3,000 labor cases, 1,500 fractures, 1,000 dislocations and 600 appendectomies, I am led to wonder how he managed to have them come out in such well-rounded numbers. . . .

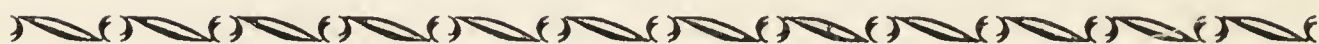


XXXVIII

INFLUENZA

“Are ye shure it do be the grip that’s layin’ me by the heels? Well, then, dang the grip!”

PRIVATE O’SHAUGHNESSY



I WAS an interne in Bellevue Hospital when this country was sore smitten with the pandemic of influenza in 1889. I went through the “flu” pandemic of 1918, as well as many other widespread visitations of the disease in the interval and the years following 1918. I feel that I have had ample opportunity to see it in practically all its diverse forms and manifestations. Many of the laity and not a few doctors seem to think that the flu and the grip are distinct diseases but they vary only in degree and in certain characteristics such as may be found in any other contagious disease during different epidemics. The grip in 1889 was in no wise different from the flu in 1918 save that the latter was even more severe and widespread. This reminds me that one Caesare Laflesche, a French-Canadian, came in one morning and announced, “All my wifes and chilluns are sick in bed with the gouzee. Sacree la gouzee!”

In many respects influenza is not unlike a common cold, but it has some marked features which make the differential diagnosis comparatively easy, and this is particularly true when influenza is known to be prevalent.

Influenza is probably more highly contagious than any other known disease. It has a very short period of incubation. It is attended with a much higher fever, far more intense general aches and much greater prostration than a common cold. It shows a notable tendency to many complications, such as broncho-pneumonia, acute nephritis, sinus involve-

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ment, gastro-enteric disorders, endocarditis, myocarditis, meningitis, encephalitis and the like. These often occur approximately in the order named, as regards frequency. It may affect the various organs seriatim. I have had cases which fully illustrate this, one such being briefly outlined in the chapter on pneumonia.

Some epidemics exhibit special peculiarities, such as nose-bleed or a tendency to empyema. I have little sympathy with the theory that sporadic grip occurs the year round. Sporadic — my eye! As well talk of sporadic itch. For all practical purposes, it is either a widespread epidemic or it has passed like an Egyptian plague. The so-called sporadic cases will usually be found, upon investigation, to be either unrecognized cases of acute tonsilitis or some other infection ranging from malaria to typhoid.

Weather and seasonal conditions have apparently but little influence. I have not only seen severe epidemics in mid-winter but in June as well. The frightful epidemic which we had in 1918 was at its height in our section during the lovely month of October. Instead of watching rafts of blue-bills on the lake, or strolling through leaf-carpeted woods after woodcock or grouse, I worked far into the night, then snatched a few hours of sleep with the night-bell and telephone disconnected. We all did this. I would not care to live through another such time of mental and physical stress.

I had a big dog named after one of the Dicken's characters, Mr. Winkle. I drove three horses, alternately. Sympathetic and sentimental ladies scolded me, telling me that it was cruel to let him follow me about on my trips — that I would kill the poor dog. They never seemed to waste any sympathy on the dog's owner. I used to say that Mr. Winkle exemplified the difference between a dog and a doctor, viz., that the dog quit when he got tired. Incidentally, he was one of a litter of seventeen, most of which were raised, and he outlived all the others.

During one grip epidemic I traveled continuously from

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Monday morning to Friday night, without rest or sleep, in order to see a large number of grip-pneumonias once a day.

That it is highly contagious is not open to question, though the exact manner in which the infection is distributed may be. In country practice, where the population is not crowded, where one is acquainted with everyone residing in the locality, this is readily demonstrated. In the beginning of an epidemic before too many distributing foci have been developed, the transmission of the disease from case to case, from household to household, and from town to town, can be traced with a precision not to be duplicated in more crowded centers. In one epidemic, for instance, it jumped an intervening space of some seven miles; the explanation was perfectly clear when all the facts were known; it was demonstrated to be a case of direct infection beyond all cavil. With a little careful inquiry, one can trace it from the initial case to the subsequent ones just as definitely as ringworm.

In any contagious disease, it is always possible to have subsequent attacks. In influenza, one may have the disease an unlimited number of times. I fully believe, however, that a severe attack confers a moderate measure of immunity; this since I have repeatedly observed that those who had a severe attack during one epidemic usually escaped, or got off very lightly in the next visitation of the disease. Influenza occurring in a pregnant woman is always a serious matter. In grippal pneumonias, nephritis is common and any tendency to delirium calls for urinalysis. One must be always on guard against hyperpyrexia. I recall two cases of grip-pneumonia, both apparently doing well, both dying one night just before I reached them. In each case, the post-mortem temperature was too high for my thermometer, and I had, therefore, no means of knowing the true record. It was over 110. Had it been possible to reach these cases earlier, they would probably have recovered under treatment by sponge baths.

As regards treatment, I have little faith in the mixed vaccines advocated by many. Remedies like aspirin admitted-

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ly give marked relief to the distressing aches and pains, but so far as my experience goes, should be used with much caution or they may do harm. Fever may be a defensive reaction, and I feel that the higher the fever, the greater the danger from the coal-tar derivatives in general. This is my view of the matter. It is, I think, that of the bulk of the profession. I am merely adding my opinion, based on a wide experience. Dogmatic statements, sweeping assertions, are not only capable of doing an immense harm but may seriously impair and discredit the author.

After trying out many different forms of treatment in the past, I at last settled down to one general line which I have had every opportunity to test thoroughly. I give a brisk purge, put the patient to bed and keep him there, sweating him freely. I give him plenty of fluids and keep him on a milk diet as a rule. So long as the skin is kept moist, there will be few pains or aches. I give about four grains of quinine every four hours. I give the quinine usually in capsule form, avoiding the pills which are prone to be insoluble. Quinine seems to me to be nearly as effective in influenza as in malaria. It certainly appears to prevent the development of bronchopneumonia or, if this is already present, to limit its extension.

Acidosis is a very frequent accompaniment of influenza, contributing very largely to its mortality. This condition not only occurs during the acute attack but is frequently troublesome in the later stages. Here the patient will complain that he cannot throw off the grip, that he feels weak, sweats freely on exertion and has no strength or ambition. His urine is scanty, acid and high-colored. He has little appetite and his tongue is heavily coated.

An essential part of the treatment of influenza lies in combating this acidosis, when present. Glucose, intravenously, is indicated in some of these cases. It will usually be found that the alkalis, if given in sufficient dosage, afford prompt relief, the urinary output becoming markedly increased and the acidity promptly lessened. For many years I

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used potassium bicarbonate almost exclusively, but of late I have found it advisable to vary this in order to maintain a better equilibrium of the alkaline bases. For this purpose a fruit diet is desirable and the changes can be rung from potassium bicarbonate, sodium citrate, lime water, etc., to magnesium carbonate and the latter is suitable particularly if the bowels are sluggish. It is not wise to give alkalis near the same hour that the quinine is given since they interfere with absorption of the quinine. In grip-pneumonias, I find the alkalis very useful, and if there is any tendency to cyanosis, which is so frequently associated with acidosis in these cases, the alkaline treatment is strongly indicated.

If there is much cough, codein or Dover's powder may be given with the quinine since something of the kind is needful to subdue restlessness as well as to control the cough. Under the method of treatment outlined, serious complications are relatively infrequent and the mortality very small and, provided the treatment is instituted before any serious involvement of the lungs or kidneys has occurred, practically negligible. Hyperpyrexia may occur, in which case I employ warm sponge baths.

Henry Dixey used to tell of being in a little Texas village, with an ulcerated tooth. The only doctor available was the proprietor of an Indian medicine show. The doctor pointed out a camp stool and got out an old pair of rusty forceps. Henry got a little nervous and suggested that ether be given him. The stalwart doctor grasped a huge mallet used for driving his tent stakes and shouted, "Ether be blowed! We stun 'em out here in Texas."

Cold baths are effective, but I prefer warm sponging since it is less disagreeable, equally effective and far safer.

As a placebo, I am accustomed to put a few drops of fluid extract of aconite in a glass of water, giving a teaspoonful every two hours. This is not entirely a placebo, as it helps to produce diaphoreses. I usually add one of the harmless coloring tablets to the mixture since it is tasteless and might

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be thrown out or taken by the patient in mistake for water. I almost spoiled one old man's noggin by carelessly washing my thermometer in his glass of gin. In young children with influenza, I use this tasteless aconite mixture habitually as it is difficult to get them to take quinine. Rest in bed and an alkaline-ash diet is usually all that is required.

Sinus involvement (a large majority of cases of acute sinusitis are of grippal origin) has, in my hands, proved quite amenable to full doses of quinine continued for a week or two together with moderate amounts of morphine or codeine. I have seldom been compelled to drain the antrum of Highmore save in chronic and neglected cases where the lining membrane was seriously degenerated. Here I commonly do a Caldwell-Luc under nerve blocking with entire freedom from operative pain. Overcrowding, lack of ventilation and unhygienic surroundings unquestionably increase both the morbidity and the mortality of many diseases, of which influenza is an example.

There is one phase of this matter which may as well be taken up here as elsewhere. If I could really believe in a personal Devil, I would indict him for having invented the kerosene heater. The old open fireplace of our grandfathers, with all its defects, gave a maximum of ventilation; but it is seldom seen now except in the South. The wood stove was much more efficient as a heater and gave sufficient ventilation. As the hot gases of combustion went up the flue, fresh air was drawn into the room through every crevice to replace them. The coal stove, provided the drafts were in good working order and coal-gas did not escape into the room, was satisfactory in most respects. The hot air furnace afforded a similar freedom from poisonous gases and, if supplied with a fan, ventilation. Steam and hot water systems afford better heat control at the expense of impaired ventilation. The portable electric heater is likewise deficient in this respect. In all but the latter, poisonous carbon monoxide was formed. This, with the other gases, were disposed of

safely in the outdoor air. Oxygen was used up but this was replaced to a greater or less extent according to the type of heater.

Contrast this with the portable kerosene heater or the gas heater. They are inexpensive and certainly give out heat, but they have three very serious faults. They consume the oxygen of the room; they fail to replace this with fresh air; they poison the air. Air-conditioning should do away with much of this. These objections do not apply to any great degree to oil stoves used in the summer for cooking. In warm weather there is an abundance of fresh air available and, used properly, little harm is likely to occur. That these heaters are advertised as odorless merely adds another indictment. Were it true, the contraption would be all the more deadly. I prefer a rattlesnake to a moccasin anytime, for the former at least gives you warning.

The Standard Oil people have been accused of many things, often unjustly. At the worst, we must render a Scotch verdict of not proven. One thing they do which is not readily forgiven. They advertise these heaters as a grand adjunct to the bedroom, the sick-room and the bathroom. How art thou fallen, Lucifer! I would love to load a fleet of scows with all such heaters now in existence and sink them in that deep hole off the Japanese coast or ship them to the most incandescent place in the hot corner of the inner circle of the seventh Hades. Now that I've got that out of my system I feel better.

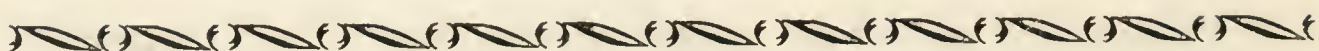
When a patient comes to me complaining of persistent headaches, depression, sluggishness, inability to concentrate, dizziness and other symptoms which may reasonably be attributed to poisoning by carbon monoxide, my first thought is to suspect that he may have been using a heater of this type. If my suspicions are verified, the remedy is obvious.

I am frequently asked for something to "purify the air" of a sick-room. Why use second-hand air? Why not open the windows?

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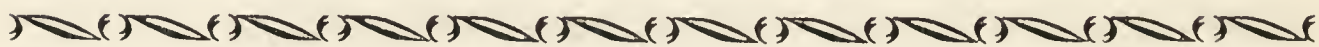
During the last few years we have made considerable progress in the study of the filterable viruses, the disease-producing agents which are able to pass through a porcelain filter and are as yet invisible through our best microscopes. Delvers in that branch of natural history dealing with microscopic life, histologists, pathologists, bacteriologists, research workers in immunity and allied problems, turning on their search-lights are gradually illuminating the dark places. Without pomp or ostentation, without hope of material profit, actuated by the noblest of motives, specialists, scientists, internists, veterinarians and other investigators are patiently and with infinite care exploring the nooks and crannies. Laidlaw has to a large extent solved the problem of dog distemper. Koen with his observations on hog influenza, Francis of the Rockefeller Institute with his frozen virus, scores of others whom I might name, nosing along obscure trails, are drawing closer, the music of the pack is striking a higher pitch and, from their various angles, pointing more and more definitely toward the causative factor of influenza and allied diseases.

To me the most encouraging thing is that these recent discoveries and new developments are in line with the established facts. They dovetail in with what many of us have long known, filling in many hitherto empty and vacant spaces. Whether we shall be armed with a vaccine, a serum, an antitoxin, some other agent or all of these, I believe that effective weapons will soon be available. Let us pray earnestly that the next pandemic will find us prepared.



XXXIX

COLDS



COMMON colds are doubtless due in a large measure to infection rather than to exposure to cold; witness the interesting experiences of Nansen and Johanssen in the Arctic regions, for instance, which are a matter of definite and scientific record. Exposure to cold and dampness is a factor of importance, but more than one factor is needed to develop such an infection as is pointed out elsewhere in the chapter on contagious diseases.

It is a matter of common observation and of personal experience that we catch cold more readily from getting the feet damp than from complete immersion by breaking through ice in midwinter; from exposure to a draft from a keyhole than from nearly freezing to death in a blizzard; from becoming partially uncovered during the night than from lying, as the young fellow explained, with "nothing over me but the ceiling." In other words, it is not so much exposure to cold as unequal exposure of various parts of the body to cold which predisposes to or invites infection.

The old-fashioned lung-protector has deservedly fallen into disrepute. It is a matter of common experience with many that they catch cold when they change from an open car to a closed one. If avoidance of change of temperature, exposure to dampness and such measures were essential in the prevention of colds, then we should move to the center of some tropic isle, shut ourselves up in a closed room, the temperature of which is controlled by a thermostat and the atmospheric moisture regulated by an automatic device, and avoiding anything in the nature of a bath, stay there until such time as some errant fly finds a way through the screen and we succumb to pneumonia from the draft of his wings.

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The other way is to accustom ourselves to changes of temperature and to develop our powers of resistance by means of cold sponging, or in other ways which will suggest themselves, and by better systems of heating and ventilation such as are coming into use rapidly.

One mother of an only daughter complained that the child was constantly catching cold. With excessive zeal she had been putting on warm clothes in the morning, changing to a lighter at 10 A. M. and about 5 P. M. resuming the heavy suit. When I suggested that the Lord appeared to change the clothing of his animals but twice a year, and this gradually, the colds ceased.

When our modern flappers, following the mandate from Paris, began to wear one scanty and a thin skimpy, three of which, held together by a bright rosette, make a neat and attractive penwiper, we were deluged with predictions of sudden death and calamitous results to the wearers thereof. As she then appeared to a pop-eyed public, she had two scruples of rayon, one scruple of chiffon, and no other scruples that could be readily discerned. Clothed with a little brief authority and little else, she assiduously cultivated the gentle art of doing without, and this so successfully that her mother and eke her granddame saw the light for the first time and fell in line, at least such lines as they still possessed. Even Eve, in her simple but attractive costume, in other words, clothed in all the magnificent splendor of nature's sweet simplicity, showed up little better. Despite all of which, we have healthier women, and doubtless just as many good and bad ones as of yore. Higher visibility was accompanied by lower morbidity, to be more concise.

It was at this period that a nice-looking young matron with whom I was well acquainted came to my office scantily clothed for that bitter January day, much perturbed over a portion of her anatomy. It was a simple herpetic eruption or cold-sore such as frequently appears also around the nose and mouth. When she anxiously asked my opinion of its

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nature, I told her that I thought it might be a chilblain. She giggled and left my office in a happier frame of mind.

Far be it from me to dictate to the female of the species who, as Kipling said, is more deadly than the male, and lest some hasty individual accuse me of being censorious, I may say that as long as we males continue to wear unwashable suits of heavy wool, we are in no position to be critical. Moreover, morality does not of necessity coincide with length of drapery. Even the fair sex can be unfair to a degree. Recently three estimable ladies were dwelling on the injustice of the double standard and the general immorality of males as compared with the chaste refinement of most women. After satisfying myself that the conversation was intended for my ears, I said, "Ladies, I have lived a long time and observed a good deal, as is quite natural to one of my profession, and I have usually found that when a man was committing an immoral act, there was commonly some woman helping him. I bid you good evening." Whereat one of them was exceedingly wroth.

As a plain, ordinary country doctor, occasionally considered unnecessarily plain and ordinary, I have been exposed to all kinds of weather, and this without injury. I am subject to colds, however, largely laryngeal and nasal, owing in a measure to a singer's nodule on the left vocal cord and to a deviated septum. The latter I can account for, but the former seems utterly unexplainable unless it was developed in early infancy. My colds have seldom if ever followed exposure, but I frequently write late at night in my office which is heated by a hot-water system governed and controlled by a thermostat. Nevertheless, I have gotten most of my colds under just such conditions, when reading or more commonly when writing at my desk for several hours at a stretch, after the day's work was as nearly ended as it ever is. I would become conscious that my throat was dry and uncomfortable and a severe cold would result, lasting as a rule some weeks.

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Eventually, I noticed that in every instance this prickly and dry sensation in the throat was accompanied by cold feet and ankles, they having become chilled while I was concentrated on whatever work I was doing at the desk. It occurred to me to reverse this process, and I went to the kitchen range, put a board on the floor of the oven and taking off my shoes, I roasted my feet and legs to the limit of endurance. The premonitory cold symptoms immediately disappeared and did not return. Subconsciously, I think I had in mind at the time the rhyme of *Ye Ancient Pedagogue* of John G. Saxe, who in defending corporal punishment for his pupils, says with excellent logic in the concluding verse of his argument:

“For as ’tis meete to soake ye feete, ye ailing heade to
mende,
Ye younker’s pate to stimulate, he beats ye other
ende!”

At any rate, I have found this an excellent way of breaking up a cold, either in myself or in my patients, in the primary stage. Quite often a cold in the early stage can be aborted by a fairly good dose of codeine. For colds, which are too far advanced to be so aborted, full doses of quinine, with or without Dover’s powder, have proved useful and about as satisfactory as anything I have tried, while such remedies as aspirin afford a measure of relief to the distressing head symptoms. As regards the various cold vaccines on the market, while I have used them more or less for many years past, I am still undecided as to their efficacy. When the nose is plugged by congestion, it is often possible to get relief, temporarily at least, by rubbing the ears until they are red.

As in influenza, many common colds are accompanied by an acidosis. Ordinary bicarbonate of soda, given freely but guarded by the usual tests, will in many cases afford relief.

In giving cough mixtures of the customary types, it is well to instruct the patient to hold the mixture in the mouth

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as long as possible, not swallowing it until compelled to, letting it slowly trickle down much in the same way that a cough drop is dissolved in the mouth. Following this method, we get the maximum of local action and the minimum of constitutional effect, which is what we usually desire.

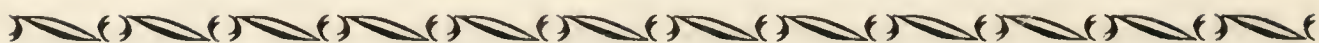
There is a popular belief that "A mild winter makes the doctors and undertakers rich," and that "A green Christmas makes a fat churchyard." I know of no greater fallacy as applied to this section, at least. A review of the mortality statistics, in conjunction with the weather records of this locality, was made a short time ago. Since accidents and epidemics of an accidental nature would tend to vitiate the results, they were ruled out. With these eliminated, there can be no question as to what the records show. A protracted cold spell invariably increased the morbidity and mortality. (Perhaps it is unnecessary to explain that the term "morbidity" as here used applies to various illnesses and, after surgical operations, to complications such as adhesions, ventral hernia or prolonged convalescence.) The reason is not far to seek. Overcrowding in hermetically sealed houses, lack of fresh air and sunlight are undoubtedly the chief factors.

There is little if any doubt in my mind that the essential factor in the causation of colds is contagion or direct infection, but, curiously enough, we know very little about the origin of this common affliction.

In the way of prevention of colds, infected tonsils and adenoids, neglected chronic sinusitis, deviated septums, turbinate hypertrophies and similar conditions are to be stressed, since they are important predisposing causes. On the whole, the best treatment which I am able to recommend can be summed up briefly: a mild purgative, alkalies, rest in bed and a carton of soft paper handkerchiefs. An interesting book to read is an added comfort. Some of my medical friends have criticized this chapter rather severely on the ground that there is nothing new in it, that it is not "up-to-now," as they say down South, and that it is old-fashioned

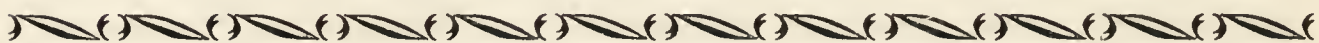
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and unscientific. My rebuttal is that when medical science finds a way to cure common colds and I hear of it, I will be "right proud" to use and to recommend it. This, coupled with the advice of the old German who sagely remarked that "peoples mitout stones should not in glass houses live."



XL

SYPHILIS AND THE VENEREAL DISEASES



SOME are born syphilitic, some achieve syphilis, and some have syphilis thrust upon them. Perhaps no common disease is so frequently overlooked by the general practitioner as syphilis, and eternal vigilance in this respect is the price of safety. It is to be noted here that extra-genital syphilis occurs with far greater frequency than we are accustomed to think. The innocent suffer with the guilty. It crops up in the most unexpected places. A negative Wassermann and a negative history prove little. A Kahn can not always convince.

Some years ago, a general practitioner who was one of the finest men I have ever had the pleasure of knowing intimately, asked my advice about an elderly woman who had an intractable ulcer on the back of her hand which was followed by a similar one on her forehead. Both slowly spread despite all his efforts to heal them. When I suggested syphilis as a probable causative factor, he insisted that this was highly improbable since "they were nice people." I persisted and he changed the subject. Some two months later a physician of long experience, in an adjoining town, asked my advice regarding the same case and I again, without seeing the patient, offered the same suggestion, which was frowned upon for similar reasons. Some weeks later, this woman applied to me for treatment. Her history was that they had a farm hand in their employ who "had something ailing him." While doing the family washing, she pricked herself on the knuckle of one hand, with a pin which was in his overalls. She had a serpiginous ulcer on the back

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of her hand, a large one on her forehead and numerous evidences of secondary syphilis. I explained the situation fully to her, dwelt on the gravity of the trouble and told her that she must remain under treatment for at least two years, possibly much longer. I put her under treatment at once, with the result that the ulcers healed promptly, whereupon she, with equal promptitude, disappeared from view. Some two years later, I received a communication from the chief of a large hospital for the insane, stating that he had a case of an unusual type of insanity in which he was much interested and that her history showed that she had, at one time, been under treatment at my hands. I gave him what light I could on her history, and a short time after this she walked into my office to tell me that on her discharge from the hospital she had received instructions to return to me for continued treatment. I cite this as a typical illustration of what has been stated in the preceding paragraph.

A recent case diagnosed by the army surgeons and the physicians in a well-equipped hospital as a case of hopelessly incurable spastic paraplegia returned to his home to die and made a swift recovery under vigorous antiluetic treatment. The Wassermann test is of the greatest value, but when this is negative or doubtful, the therapeutic test, as in this case, is of immense service. When in doubt, play trumps, and a few shots in the arm may bring gratifying results. The safe way is to suspect every case, and then clear them from suspicion if need be.

Cases of perforated septum, chronic laryngitis, and pulmonary involvement are probably tuberculous, but if we rule out syphilis before arriving at a decision, we will avoid trouble not only for our patients but for ourselves. Such cases should be approached with an open mind, without prejudice. Ulceration of the bowels or rectum, a history of repeated miscarriage, of hydrocephalic or still-born children, cases of ozaena, keratitis, iritis, and a thousand and one other manifestations should at once arouse suspicion. Not that

these may not occur in non-syphilitics, or on the other hand independently of an actual syphilis.

I have a case of active syphilis at the present time, both she and her husband showing a positive Wassermann and both being under treatment by salvarsan and mercury. She developed an acute iritis which did not show improvement under atropine and vigorous antiluetic treatment. The salicylates were substituted with prompt results. Later, she had distinct attacks of rheumatism in other regions, which likewise yielded to the salicylates. One is forced to the conclusion that here I had two separate infections to deal with either of which was quite capable of causing an iritis, and had at least winged it with the second barrel.

The "therapeutic test" went into reverse gear in this instance, but it worked and, after all, that is the chief end of the doctor. The iodides are said to have no influence on syphilis proper, only on certain manifestations of the disease, some of the by-products like gummata, yet I have seen cases of primary chancre which refused to heal under the usual treatment but gave immediate response when iodide was added. One must not be too dogmatic in his assertions regarding medical matters. Old man Graham said it was ordinarily considered that rules should be made out of cast-iron, but he believed they should be made like an India-rubber band so that they could stretch out for the individual case and come back in shape without injury. These brief references to an omnipresent disease of the gravest kind are merely intended to emphasize some points which will bear repetition.

Many cases of true chancroid, phagedenic or other, are infected simultaneously with syphilis and in some instances the graver infection may be overlooked. I recall several instances of phimosis and balanitis in which it was necessary to do a circumcision, only to discover later that I had an acute syphilis to deal with. Here a needle puncture through a rubber

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glove might have proved disastrous to me and the mere thought of it gives me a crop of goose-pimples.

A simple and effective treatment for chancroids proper is to powder the ulcer with any of the dry healing powders like aristol or bismuth formic iodide, wrap a pledget of absorbent cotton around the organ back of the corona glandis and hold this in place with a rubber thread band, one not tight enough to cause any constriction but merely to hold the cotton in position to prevent the prepuce slipping forward, allowing desiccation to occur. These germs ordinarily thrive only in the presence of moisture. Dryness inhibits the growth of germs whether in living tissues or in the culture mediums of the laboratory.

The same procedure is remarkably efficient in gonorrhoeal infection occurring in patients with a long prepuce. Such cases are prone to have a severe infection and run a protracted course. The reason seems obvious. To permit a case of Neisserian infection to go about with the meatus continually bathed with the infectious discharge is to invite an indefinite continuance of the disease through constant reinfection.

When a case of orchitis or epididymitis fails to respond to proper local measures, support of the inflamed organ, etc., it is well to bear in mind that many of these cases immediately improve under mercury, potassium iodide or both. The possibility of multiple infection in these cases must never be lost sight of, for most general merchants carry more than one line of goods and the business of prostitution affords no exception.

When a bubo forms and the glands break down and suppurate, I have had infinitely better results by a simple incision along the line of Poupart's ligament, shelling out the infected glands with a gloved finger, than by attempting to get a primary union by excising the mass in toto. Nature has already walled off these glands, and if the surrounding, partially walled off tissues are undisturbed, they clean up readily while the so-called radical procedure merely opens

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up new avenues of infection, and a satisfactory outcome is the exception rather than the rule.

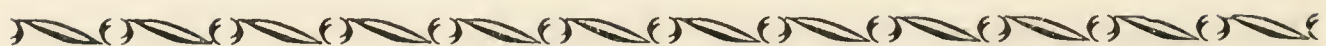
Above all, these venereal cases should pay cash down and they should be warned, in language that will reach their nerve centers, that they are menaces to their best friends. One rotten apple can spoil a barrel of good ones. Their pace-makers and runner-ups should receive treatment as well. The man who has a "social" disease should at least be taught to seek better society in the future, if he is hopelessly immoral.

There are still too many people who consider any open discussion of the mis-called "social" diseases exceedingly shocking. Some of these who fatuously blindfold themselves and their children to the truth are inevitably destined to receive a worse shocking. Do they think that they can do away with these horrible afflictions by completely ignoring them? Do they believe that by doing away with *all* danger signals there would be fewer casualties? Do they really believe that we go to all this trouble to put up warnings for other than altruistic motives? Do they imagine for a moment that doctors and nurses who devote their lives to the alleviation of human distress and suffering, men and women who warn their children of these dangers in plain words, who face these realities with unflinching courage, who know about these things to the last repugnant detail, are rendered more immoral thereby? If such is their *real* opinion of us they should be quietly guided to the front gate and dispassionately kicked off the premises.

Uncle Eph says, "A naked body sometimes don't look quite decent but they's times when a naked soul looks a heap-site wusser. We had a new preacher to church last Sunday, a young feller. He preachified on how shall we escape if we neglect so great salvation, if I rec'lect rightly. Fust off he told us all about the glories of salvation and the Heaven waitin' for us; an' then he give us the shivers when he told us where we would go if we neglected salvation an'

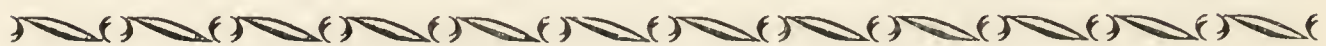
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didn't get saved, an' he drawed it pretty strong so lots of us began to puspire some. And then he told us *how to escape 'sposin' we did neglect*. That was jest what we was all lookin' for. Feller's jest out of college but if we can get him to come here, instead of his goin' to some big city church, we'll be blamed lucky."



XLI

TUBERCULOSIS



SO MUCH has been written on the subject of tuberculosis that I shall confine my remarks to a few observations only, such as they are and for what they are worth. In the locality where I have had the pleasure of practising medicine (despite its hardships and its tragedies it is still a pleasure) there lives an elderly woman without near relatives. She has a chronic pulmonary tuberculosis with profuse expectoration. She goes from house to house doing menial work, as the opportunity of earning an honest dollar may arise. She is undoubtedly broadcasting tubercle bacilli throughout several townships, in the various houses in which she is employed. She is not under medical treatment and does not consider herself seriously ill so long as she is able to work. She cannot be adjudged a criminal, although, in a way, it is a crime of the first magnitude. She is honest, industrious and law-abiding, therefore no jail-bird. She is not a pauper but self-supporting, accordingly the almshouse is no proper place for her. In her own way she is as proud as Mrs. Apollyon Lucifer and will accept charity from none of us. With her limitations, mental and environmental, it is impossible to convince her that she has tuberculosis and, in consequence, is a public menace. We have sanitariums for incipient cases and for others more advanced but no adequate provision as yet is made for patients of her sort. We must not be too vainglorious over the advanced state of our civilization so long as proper institutional care for such cases is lacking. The public should be protected but in a manner which will not unduly humiliate such worthy but unfortunate people.

It is difficult to make many of our people realize the ad-

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vantage of fresh air and, in many cases, its absolute necessity. If we were obliged to purchase it we would value it more highly. In our Northern climate during the long, severe, and occasionally sunless winters, it seems almost necessary to seal up our houses hermetically. As physician for a nearby Indian reservation during a period of years, I have had every opportunity to observe the evil effects of overcrowding, lack of ventilation and general insanitary conditions among them. I recently saw, in one house on the Reservation, an upper room with seven beds in it. Most of these beds had more than one occupant. The chief cause of death on the reservation is tuberculosis and the chief morbidity from this and syphilis.

Overcrowding is not the only factor in their susceptibility to tuberculosis. Once an Indian develops it, he is practically doomed, showing little resistance to the infection as compared with the whites. This is to be expected, since it is in line with what we already know regarding savage races undergoing civilization and is in accord with well-established facts respecting birds and animals.

The turkey, for instance, having been domesticated comparatively recently, is much more susceptible to disease than the hen, the latter dating back, as a barn-yard fowl, to the dim past. Given sufficient time, our Indians will gradually acquire a much greater measure of immunity to many diseases. Their forbears were accustomed to the free life of the woods and the drafty tepee; their descendants will slowly develop a tolerance for heated houses and second-hand air. In confirmation of this view, statistics show that this race, which for many years was apparently slowly dying out, now shows a moderate increase. Many cases of tuberculosis in these people are complicated with syphilis and we often find that cases which have been pronounced bone tuberculosis are amenable to anti-syphilitic treatment. Cancer is comparatively rare and I have yet to see a case in a full-blooded Indian.

In the rural districts we not infrequently find tuberculosis

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patients who, owing to lack of funds or other reasons, are unable to spend a lengthy period in a sanitarium. Other cases are difficult to convince that institutional treatment is advisable or essential to their recovery. I have often been able to persuade such patients to go to a sanitarium for a few weeks, advising them to observe carefully the manner of life which is there followed in order to combat the disease, to take intensive training, as it were. What they actually see and experience is far more convincing and makes an infinitely stronger impression than any amount of advice and verbal instruction from the family physician. I fully realize that this at best is a half-way measure but a half loaf is better than no bread.

Good hygienic surroundings, direct sunlight, fresh air, ventilation of dwellings and business places, the avoidance of dust and, in so far as practicable, of direct contact with cases of open tuberculosis, the testing of cattle and the pasteurization of milk, the prevention of promiscuous spitting, the removal of infected tonsils, which so frequently afford a port of entry, and the maintaining of nutrition are the high spots in prevention.

Raw eggs, if well borne, are exceedingly useful in wasting diseases. That raw eggs are better than cooked eggs can be readily demonstrated. Many people object to raw eggs and with good reason. Some acquire the trick of swallowing them whole (except for the shell) like a large elastic capsule, but I doubt if they ever really enjoy them when so taken. We are, most of us at least, agreed that a fried egg should be served hot and that it needs butter, pepper and salt to properly season it. Let us consider how raw eggs are usually given; we beat them up with milk, sugar and brandy or vanilla as a flavoring; we give them in wine, in lemon juice and in various ways, mostly vile. Is that any way to treat a decent, respectable and well-born egg? If we fried an egg in tasteless mineral oil, set it in the refrigerator to cool and subsequently served it without seasoning of any kind, would a few drops of vanilla or a dash of sherry make it appetizing? On the contrary, it would

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still remain a flat, tasteless, and undesirable mass of calories. (Mess might be more appropriate.) Why not treat a raw egg with the same consideration we show a fried one? Why not turn that which is a disagreeable duty into one of positive pleasure? A one minute egg does not serve the purpose, if so boiled. The outside will be hard and leathery while the inner portions and the yolk are not even warmed.

Take a teacup, put a pat of butter in it and set the teacup in the oven to warm the cup and melt the butter. Place two unbroken eggs in a sauce-pan on the kitchen table, not on the stove, and pour enough boiling water over them to cover them completely. Do not cover the saucepan. Allow the eggs to remain for five minutes by which time the eggs will be hot but not cooked. The white will be slightly clouded, this varying to some extent with the temperature of the room, the size of the egg and the capacity of the saucepan. Break the eggs over the butter which has, by this time, melted, add as much pepper and salt as desired, break the eggs up thoroughly with a teaspoon and eat them with your toast or drink them down, as you prefer. They *taste* exactly like fried eggs. I have trained the people up here to "cook" their eggs after this fashion and they dub it "the Macartney egg," which sounds rather funny, and many of them will eat eggs in no other form.

It is the fashion to decry the use of medicine in tuberculosis and it is easy to understand why stress must necessarily be placed on other measures. Nevertheless, many of us are still of the opinion that cod-liver oil and creosote, or some of the derivatives of the latter, serve a useful purpose. Cod-liver oil, as previously stated, should be given before, not after, the meals, in order to avoid disagreeable eructations. When given in combination with malt extract, it can usually be taken without gastric disturbance.

As for creosote and its allies, I have a decided leaning toward the straight beechwood creosote since it seems to me to be more efficient than the comparatively tasteless prepara-

tions. It is quite true that its taste and odor are objectionable but I have for many years been in the habit of giving it in the form of chocolate-coated friable tablets, each containing two grains of creosote. I have ten thousand of these made up from time to time and thus get them fresh and soluble. They are not at all disagreeable to take, are inexpensive, efficient and not likely to disturb the stomach. I have been much gratified by the results obtained through the use of these tablets when no other medication was being given. I commonly give two or three of these tablets before each meal. They are also useful in chronic bronchitis.

This creosote matter reminds me that many of my patients ask me for what they call my "rat poison" cough mixture, stating that most other cough mixtures either cause nausea or show a tendency to dry up the cough, thus doing more harm than good. This preparation contains, instead of the usual sedatives like codeine, morphine and the like, carbolic acid in half minim doses to each teaspoonful. The carbolic taste is disguised to a certain extent by essence of peppermint, the formula for the syrup varying in accordance with the requirements of the individual case.

This does not disturb digestion or nauseate, does not check expectoration and, in a general way, acts much like the creosote. After an extensive use over a long period of years, I can say that I have never seen any harm result from its use and carboloria has never occurred, though I caution my patients to discontinue its use if the urine should become smoky or greenish in color. It seems fully as effective in relieving the cough as the opiates. This fact alone is a manifest advantage in these days of Harrison Law regulations which demand so much red tape, even in the case of that quick-acting emetic, apomorphia, which is still stupidly classed by officialdom as a narcotic. My own feeling in regard to the latter is that, if anyone wants to become an apomorphia fiend, I would grant him full personal liberty if he will only keep a reasonable distance on the lee side of me.

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In dealing with strangers or others whose confidence I do not possess, I find it wise to disguise the carbolic, the general impression being that it is a deadly poison, which it undoubtedly is if improperly used. So is strychnia, yet we all prescribe it without the slightest fear, in proper dosage, when indicated. The general attitude toward carbolic is that of Ikey Goldstein who was walking down the Bowery with Abie. As they were about to separate for their respective clothing emporiums, Abie said, "Au revoir, Ikey."

"Vat is dat?" inquired Ikey.

"Dat is good-bye, in French."

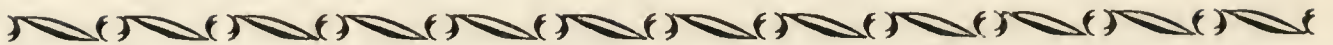
Ikey waved his hand. "Carbolic acid, Abie."

"Vat is dat?" asked Abie.

"Dat is good-bye in any langwich."

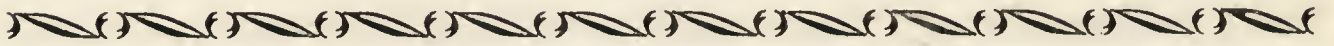
The doctor and the dispenser are the only ones that really need to know what the mixture contains.

Since the literature of the medical and surgical aspects of tuberculosis would fill several warehouses, it may be summarized by stating that the tuberculous patient should be sent to a good sanitarium when this is possible. The questions of inducing collapse of a diseased lung by artificial pneumothorax and similar procedures, for instance, need no discussion here.



XLII

PERTUSSIS



WHOOPING COUGH is a serious malady when it gains entrance to a household with many children. If you doubt this, try it sometime. As in other diseases, there are many cures, of a sort. Most of them show their greatest efficacy in the fifth or sixth week of the disease, at which time, with or without medication, an amelioration may be anticipated. I think I have pretty thoroughly gone the rounds of the remedies advocated for its cure. Bromine, antipyrine, the valerianates, all are of use in controlling the spasm. Belladonna has been effective in this respect. Adrenalin, and some of the thymol preparations have been beneficial at times. The sole remedy which, in my hands, has seemed to have any curative effect on the disease itself, is pertussis vaccine. Many authorities say that it is of no value either as a preventive or a curative agent.

I used it for a number of years and felt that it had a limited measure of control over the duration and severity of the disease. Then a young baby was brought into my office in the early stage of the disease. I had never seen a case develop such severe paroxysms and it seemed to me that the child would likely die in my office. Desperate cases require desperate remedies, and I gave what seemed to me at the time an enormous dose of the vaccine and directed the mother to hurry the child home. The infant developed no untoward effect and within twenty-four hours was decidedly better.

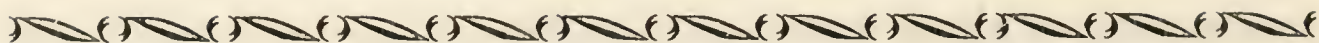
A little later, while in Florida I had a case of a young child with a multiple infection. He had been exposed to measles and whooping cough and came down with both diseases simultaneously. He developed an extensive broncho-

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pneumonia with an excessively high temperature. His respirations averaged ninety-six on repeated counts. He was constantly cyanosed, desperately so during the paroxysms. Though his case seemed quite hopeless, I sent to Tampa for pertussis vaccine and gave it to him with exceeding liberality. The choking from the whooping cough was promptly relieved, and he made an excellent recovery. Since then, I have not hesitated to give it in any dosage that seemed necessary to control the disease, and I took the matter up with the health authorities of the State. I received a communication from them under date of August 7, 1928, in which it was stated that the concentration of this vaccine, both prophylactic and therapeutic, had been increased from four thousand million to ten thousand million organisms per c.c. The precedent of tomorrow is made by breaking the precedent of today.

I have recommended its liberal use to some of my associates, and we have materially increased the dose of the present product over that recommended in the instructions accompanying it, and none of us have observed any unfavorable results from its use. Since we have, so far, seen no ill effects, we are not in a position to fix a limit as to the maximum dose. We can only say that the dosage formerly recommended is, in our opinion, utterly inadequate. Since we have given it in a large number of cases and we are agreed in the matter, it does not seem to be one of those instances of unconscious self-deception in the interpretation of results.

Whooping-cough vaccine is gradually being perfected and I fully believe that it will eventually reach the point where it can be relied on effectively to control the disease itself in a way which symptomatic treatment cannot hope to accomplish. At any rate I have no qualms, or at least only two or three very little qualms at times, about giving our present product quite freely to these little patients, for they, and their parents as well, need all the help we can give them.

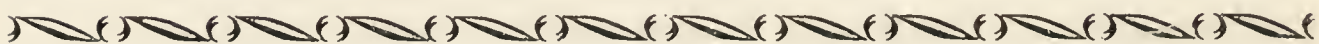


XLIII

INFECTIOUS JAUNDICE

"All seems infected that the infected spy
As all looks yellow to the jaundiced eye."

POPE



NOT long ago I had some correspondence with the health authorities of our State and with others regarding a supposedly infectious jaundice of a mildly epidemic character. When I stated that I had seen quite a number of such epidemics during the past forty years, they seemed a bit incredulous. I certainly saw a considerable number of these apparent epidemics and, mistaken or not, I can only maintain my self-respect by painting the thing as I see it for the "God of Things as They Are." Of late there has been much discussion as to the identity of such mild epidemics with Weil's disease. Never having seen the latter, I am in no position to express any opinion. The epidemics that I actually saw were confined almost exclusively to school children or those of school age. A number of the school children would usually have it at about the same time, then I would see no more cases for several years, possibly. Chicken-pox, mumps, and other infectious diseases commonly made their visitations in much the same way. I had no doubt in my mind that this jaundice was mildly infectious.

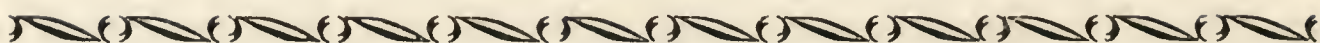
I recall one case where the mother of a family, aged about fifty, came down with a well-marked jaundice. At her age and in the absence of pain of any moment, I felt that I could rule out a cholecystitis or a stone in the common duct and I was inclined to believe that I had a malignant growth to deal with. There had been no chill or rise in temperature such as one often finds in gallstones. I was about to send her to the

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hospital for roentgen examination or an exploratory laparotomy when three of her children developed jaundice and I exercised the privilege accorded women and doctors — I changed my mind. Each made a prompt recovery under the simple treatment I now outline.

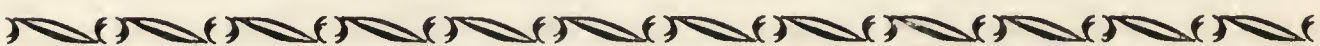
As a rule, they are not sick enough to be actually confined to bed. I have seldom met with the gaseous distention of which most writers speak and have not restricted the diet materially. The textbooks recommend, almost invariably, an initial dose of calomel. I am not opposed to the use of calomel at all and I followed this plan in my early cases. It seemed to me to do no good whatever, the stomach becoming upset and the jaundice immediately growing deeper, with no bile in the stools as a result of the calomel. If it does not remedy the clay-color of the stools, I can see no reason for employing it except on the old hypothesis that it "is good for the liver." All of my cases, except a few that I used as controls, recovered rapidly under the ordinary phosphate or orthophosphate of soda. The control cases likewise made a good recovery but the duration averaged about three times as long.

I give a teaspoonful of the straight phosphate in a cup of hot water three times a day, before meals. I use no other medication. There is no reason, so far as I know, why the effervescent phosphate should not be used but the dose must be larger and the plain phosphate has no very disagreeable taste. I may be all wrong about both its epidemic nature and the results of treatment, but I am giving it as I see it.



XLIV

ERYSIPELAS



IN THE year 1889, I was in charge of the Erysipelas Pavilion in New York for a time. At this period there was much confusion as to what constituted erysipelas. The profession recognized three forms — cutaneous, cellulo-cutaneous and phlegmonous. Practically any old thing, however, was classed as erysipelas. I had cases of acute eczema, sunburn, ivy poisoning, etc., entered as erysipelas. I had also a case of scarlet fever, one of glanders and one of broken fibula with abscess formation due to the patient walking around on it while on a protracted spree. Even at this day much confusion exists in the minds of some writers as a comparison of a few modern textbooks will show.

When my service at the Pavilion ended, I was satisfied that the term erysipelas could be properly applied only to cutaneous erysipelas, since this was evidently the only one of these diseases which seemed a distinct entity. Erysipeloid is the only other affection which, so far as I know, closely resembles it. True cutaneous erysipelas is due to infection with the streptococcus of Fehleisen. There is usually a sharp chill followed by rapid pulse and fever and, in a short time, by evidences of cutaneous involvement, the chief characteristic of which is a raised, sharply defined edge at the advancing border of the red erysipelatous patch. Cases of so-called recurrent erysipelas have, so far as my attention has been called to them, proved to be cases of acute eczema of the recurrent type or other forms of acute dermatitis and wholly lacking in these characteristics.

At the time of which I speak, I thought I obtained excellent results from the use of large doses of calcium sulphide,

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but of late I have wholly abandoned this line of treatment, owing to the difficulty of obtaining pills of this drug which are not altogether inert. The idea then prevailed that the spread of the disease could be prevented by surrounding the erysipelatous patch with a fence of iodine, of nitrate of silver, of carbolic acid or by subcutaneous or intracutaneous injections of various remedial agents.

Having an abundance of material at my disposal, I tried out these various plans of procedure, and likewise used control cases. I found something that *seemed* to work. At a medical society meeting, shortly after this, there was a discussion of the "fencing" line of treatment. I was in a position to say with the utmost truthfulness that I had secured decidedly better results from fencing the lesion in with Stafford's Commercial ink that I used with the then fashionable stylographic pen, than with any of the other agents similarly used to limit the spread of the disease, this method being also used in my control cases. My personal and private opinion is that almost any other pigment would have proved just as serviceable provided it would not fade in the wash or rub off. Hippocrates recommended the application of cold water. A review of the present day textbooks shows that the idea of "fencing" in the disease still has its advocates.

It is no more than fair and just to state that some of our foremost authorities endorse Powell's plan of painting around the infected area with carbolic acid. Stafford's ink could have no possible influence on the morbid process, being merely recorded in order to show how easily we can be misled into believing that because a certain act was followed by a given result, said act was necessarily the cause.

One French-Canadian patient, when I informed her that the cause of her symptoms was pregnancy, said, "I know exactly when it happened. I was on my knees in church saying my beads." I could not question the sincerity of her belief, but I am still unconvinced of the accuracy of her conclusions.

Various serums and remedies of this type have come into

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use, but I have had insufficient experience with them to draw any worth-while conclusions. It is an erratic disease and a few cases prove little.

Alcoholics require free stimulation. Autogenous vaccines are reported to give good results. For local treatment I have found ichthyol ointment apparently very serviceable, also a dilute solution of that other sulphur compound, Vlemingx's solution.

Erysipelas is self-limited. Eventually it stops spreading and apparently gives the "fencing in" enthusiasts convincing proof that their methods are successful.

XLV

TETANUS

TETANUS is always a very serious disease and the suffering involved is extreme. The mortality is very high. I have had the misfortune of having seen many cases but the good fortune of never having lost one save an infant with tetanus due to infection from a filthy umbilical cord dressing, and this case was moribund when first seen.

One of my earliest cases, seen some forty years ago, is recalled to my mind by a letter received from her today. She was then a little girl living in the neighboring Province of Quebec in an isolated farmhouse some distance from the main road. An extension of the house, open toward the south, was used as a woodshed and as a shelter for horses when hitched to a cutter or other conveyance. She stepped on a needle among the chips and rubbish in the floor of this shed. The needle broke off in the sole of the foot. Under cocaine anaesthesia, using every precaution to maintain asepsis, I elevated a semi-circular flap from the sole of the foot, exposing the broken needle, and after removing this, used a bichloride wash. The wound healed primarily, the stitches were removed and the little patient discharged.

Some two weeks later, in the gray of a November morning, I received a call to this case, and upon my arrival found my patient having tetanic convulsions, the pain running up directly from the injured part to the back of her neck. I sent a hurry call for the nearest physician, and after he anaesthetized the patient, I excised *en masse* all the area about the needle puncture, including a liberal amount of the surrounding tissues. On afterward dissecting the excised mass, I laid bare the site of the needle puncture and found an area of

greenish-black necrotic tissue with an extremely offensive odor but no true pus so far as I could determine. What struck me forcibly at the time was the absence of any apparent soreness, or any evidence of inflammatory action in the sole of the foot, in so far as one could see from the clinical signs. In other words, although dissection showed a marked infection, this was not evident from external appearances. At this time, tetanus antitoxin was unknown, and my object in excising the mass was to get rid of the original germ colony, trusting to the phagocytes, to use the term then employed, to pick up any straggling bacilli that had entered the system. From this time on, the convulsions steadily diminished in frequency and severity. In a few days she was quite well, save for the vacancy in the sole of her foot, which healed by granulation.

At the present time, I find many who believe that tetanus antitoxin is a comparatively new discovery, dating from the time of the World War, this despite the fact that many of us were using it as a matter of routine long before the war was started. About the time that tetanus antitoxin was first introduced, I had a very instructive case. A boy living in a near-by town stepped on a nail while in a horse-barn. I found a punctured wound in the ball of the foot. Enlarging the puncture in the sole, I introduced a sterile silver probe and, following the track of the nail, encountered bare bone at a depth of about 20mm., where the nail had evidently struck the head of a metatarsal. As had been my custom for years in such cases, I fused a bead of nitrate of silver on the end of the probe and carried this down to the bone. I left, anticipating no further trouble, but he subsequently developed lockjaw of the severest type. I anaesthetized him and split the foot completely through from the web between the toes through the region of the puncture and between the metatarsals to the tarso-metatarsal junction which gave me full access to the infected area. The condition revealed was instructive. The nail had penetrated, as previously found, to the head of the metatarsal and this portion of the wound,

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which by means of the bead of nitrate of silver had been cauterized, *was perfectly healed and in excellent condition*. The nail, however, had glanced off the head of the metatarsal, forced the bones apart and had nearly emerged on the dorsum of the foot, and this portion of the wound which the silver had failed to reach was of the greenish-black color heretofore noted and had the same characteristic foul odor. My treatment had been good enough, so far as it went, but no further.

A thorough removal of the infected tissues was attempted, but the bone being involved, I am satisfied I did not get all of it. All available tetanus antitoxin was given him, the wound was treated openly and the convulsive seizures which were of exceptional severity gradually subsided. A further supply of antitoxin was obtained and used, but I was unable to satisfy myself that it had any marked effect, feeling sure that the excision and open treatment were the main factors in his ultimate recovery.

I believe that tetanus antitoxin is largely useless so long as the original hot-bed, the primary focus, the mother colony, remains. If this is not good logic, then I do not understand the meaning of the term. I believe it is an agent of great value, however, when properly used. I have given it in a very large number of cases as a preventive measure with apparent uniform success. I have advised its use in other cases and occasionally, where my advice was not followed by the attending physician, I have known fatal tetanus to supervene. The case seems to me to be proven from either angle, and I have great confidence in it, but in the treatment of the full-fledged infection the primary focus should be removed in toto where this is at all possible.

On this assumption, one such case may be worth recording here. I was recently called to see a man who had suffered a rather superficial wound of the hand from a blank cartridge. The wound had healed without any apparent trouble, but he later developed lockjaw and was sent to the hospital by the

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attending physician. He was repeatedly given large doses of tetanus antitoxin, but steadily grew worse and a wholly unfavorable prognosis was given by the surgeons in charge. Upon my arrival at the hospital, I found him with a high fever, rapid pulse, rigidity of the muscles of the neck and jaw together with more or less constant convulsive seizures. With the full consent of the surgeon in charge, I operated upon him, assisted by my associate, Dr. B. T. Smith, who had accompanied me. The wound in the hand was in the palm near the base of the ring finger. It was not reddened, painful or apparently sensitive to the touch, but was slightly puffed. I attempted to excise a block of tissue at the site of the original wound which still showed some powder stains. On cutting through the palmar tissues, a small mass of thick gelatinous and somewhat purulent material was extruded and the connective tissue underneath showed the characteristic greenish-black discoloration.

What I thought would be but the work of a few minutes proved to be a rather tedious dissection. I followed up the lines of necrosed and discolored tissues in the palm of the hand and along the little and ring fingers, making as complete a dissection as possible, removing all the obviously infected tissue. When this was completed, it was clear that there was little hope of saving the fourth and fifth digits for any useful purpose. So much connective tissue had been removed that extreme contraction and consequent crippling was bound to follow. Taking this (and the greater danger of leaving possibly infected tissue) into consideration, it was deemed best to remove both of these fingers which was accordingly done, no attempt being made to close the wound. Pathological reports showed the presence of the tetanus bacillus in the excised tissue. The patient had more convulsive seizures, which gradually diminished in intensity, and made a slow but complete recovery.

The point I feel impelled to stress is this: in none of the large number of punctures, treated by me with the nitrate

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of silver bead, did tetanus occur, save in the one instance related and in this case there was no infection whatever in that portion of the wound reached by the silver. Very many cases had been so treated before the time when antitoxin came into use.

So far as external appearances are concerned, the local indications, both objective and subjective, are untrustworthy, deceptive and misleading, showing little or no evidences of inflammatory reaction. Despite this, I have invariably found a focus of seriously infected tissue with a greenish discoloration and an offensive odor but with little inflammation or any pus of the usual type.

While all of my cases, save the punctured nail-wounds, have been treated by excision and the wound left open, with a loose packing of iodoform gauze or gauze soaked with peroxide of hydrogen, and in the earlier cases without antitoxin, they all recovered. It seems reasonable to suppose that, in view of the lessened but still very high mortality in this disease following the almost universal use of antitoxin, excision and the open treatment were the chief factors in the results in all of my cases.

It has been amply demonstrated that the symptoms of tetanus are purely toxaemic, the bacilli almost invariably being confined to the region of the primary wound; the cases in which the bacilli are found in the blood, in the lymph spaces or other body tissues are extremely rare. This is the accepted view but, if this be true, why is so little stress laid upon complete extirpation of the primary focus? Once the main toxin factory, where the bacilli most congregate, is put out of commission, we have in tetanus antitoxin an agent of undoubted service. Its value has been demonstrated beyond question.

In view of my experience in these cases, backed up by bacteriological reports, I cannot agree with the teaching in many of our colleges and in a large proportion of our textbooks, to the effect that once the disease is well established and severe

convulsions have developed, the case is apt to result in disaster, ignoring almost entirely the sound surgical principle of removing the primary focus as completely and as thoroughly as possible. I recognize, of course, that in some cases this is impossible to do when vital and inaccessible organs are seriously involved, but such cases constitute but a small percentage of the total, so small in fact that they are seldom referred to in discussing the treatment of this infection.

After making the above statements, I think it may be wise for me to take a day off from my typing in order, as Bugs Baer says, "to recuperate from what is going to happen." I have seen signs of threatening winds.

At any rate, I hope to get off with merely a sharp reprimand and without a warfare of words. It is a matter for further trial, not for dictionary debates.

XLVI

“PNEUMONIA”

IF I appear to devote too much space to the discussion of pneumonia, my apology is that a condition of such widespread prevalence and appalling mortality warrants it. Mortality tables usually assign it to first place in the list of fatalities from acute infection. Certainly during influenza epidemics it heads the list. Much that I have previously written on this subject I have here condensed, eliminating to a large degree what can be found in the standard treatises.

An intensive campaign has been waged against tuberculosis, which usually heads the general mortality list. We never hear the slogan, “No pneumonia in 1950,” as in tuberculosis. Why has not the pacemaker of tuberculosis, until just recently, failed to receive more consideration? Simply because we have no real solution to offer — no thoroughfare. There are two approved ways of maintaining a discreet silence on an unpleasant subject. One is to ignore it, the other is to talk volubly and persistently about something else. Why not be honest and concede that we are still largely at sea in its management?

During the past century the treatment of pneumonia has passed through many phases, many radical in their nature. Blood-letting, tartar emetic, poulticing, digitalization, cold air treatment, ice, antiseptics, type-serums and what not, with innumerable varieties of the what nots. If we study the old statistics of twenty-five, fifty, or a hundred years ago, we must admit that present-day methods have reduced the mortality little if any. We are still divided in opinion between depletion and stimulation, the use of cardiac sedatives and heart tonics, the employment of cold compresses and hot

poultices, between the avoidance of chest exposure and the open-air method, the advisability of using serum or not. We have the dangers of over-medication on the one hand, and the negative nihilism of that school which insists that it is a self-limited disease over which we have no control. All of which lends color to the view that we *have* little control over the pneumonic process.

At the present time, the prevalent view is that it is self-limited, cannot be aborted, is uninfluenced to any extent save by serum treatment. It is self-limited, beyond doubt, but right here we leave the solid ground of fact and step blithely into the limitless sea of opinion. We should never accept as fact what is incapable of proof. One case which has been benefited by treatment, a single case which has been aborted, is sufficient evidence that these statements are untenable. The burden of proof lies with the opposition, and this no man can furnish since it would be necessary to bring in evidence every case of pneumonia since Adam made his debut, in order to show that none had ever been aborted. The claim that it is never aborted is worse than foolish; it is tiresome.

I may as well admit that I am unorthodox. You are under no obligation to agree with me, nor do I feel under any obligation to apologize for my heresies so long as the mortality remains where it is. I maintain that pneumonia can to a large extent be controlled by treatment and that in many cases it can be aborted. Moreover, I am not only a heretic but an iconoclast, since I have maintained stoutly since 1911 that pneumonia is not a disease at all. Not a disease, but a morbid condition attendant on other affections and infections, a consolidation of lung tissue occurring as a complication in a large variety of infections, diseases and injuries. The term itself is an outworn heirloom from the remote past. Etiologically, it includes very many and distinct diseases.

Time was when dropsy was considered a disease. Inflammation of the bowels was a disease, and poulticing with a

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black cat split open and applied to the abdomen was a sovereign remedy. A dozen different infections were conveniently classed as erysipelas. Rheumatism is still a term applied to a host of maladies of diverse origin. We have made some progress. Typhus, typhoid and paratyphoid are no longer confounded. Cutaneous erysipelas is no longer classed with erysipeloid, cellulitis, and deep-seated phlegmons, as formerly.

What is pneumonia? A pulmonary consolidation, with a fairly definite symptom complex. It is one of the most fatal complications of influenza. It is the thing we dread in whooping cough and measles. It is a frequent accompaniment of diphtheria, typhoid, and other infectious diseases. It occurs in connection with pulmonary tuberculosis. It often follows a fracture of the ribs, a contusion of the chest wall, or a gunshot wound of the lung. In senile fracture of the neck of the femur it is a common and fatal sequel. It is an accident in etherization from inspiration of food or septic material. Cases of acute alcoholism and delirium tremens are prone to develop it. It is the terminal phase of many cases of chronic nephritis, of diabetes, of a host of other chronic diseases. It is the most common immediate cause of death in the aged. It is not infrequently epidemic in jails and almshouses. It is an unexpected finding at autopsies. The list might be extended indefinitely.

We speak of lobar-pneumonia, broncho-pneumonia, influenza-pneumonia, pleuro-pneumonia, tuberculous, syphilitic, hypostatic pneumonias, the recurrent pneumonias of certain types of cardiac disease. We attribute it to shock, exposure, depression, to a diplococcus, a pneumococcus, or some other deadly cuss hibernating between our last molar and our — no, not our wisdom tooth, surely. And we call this a disease! It is a morbid condition, an inflammation, a pathological lesion occurring as the result of infection, of the parenchyma of the lung as a complication of many other diseases and illnesses, but not in all these various forms a distinct disease. We speak of peritonitis as a localized inflam-

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matory process possessing certain characteristic features, but we use it as a general term knowing that the underlying diseases are as varied and as numerous as the abdominal contents and the germs which may infect them.

Is pneumonia a germ disease and contagious? Yes and no. The pleuro-pneumonia of certain domestic animals appears to be. Pneumonia is apparently epidemic at times in crowded and unsanitary conditions. The question obtrudes itself — is this pneumonia pure and simple, or are these instances of some acute general infection in which pneumonia is a fairly constant lesion? We have the pneumonic form of many infections, from bubonic plague to psittacosis. Certainly, this has little in common with hypostatic and senile pneumonia. The evidence so far advanced merely shows that it is a condition quite commonly resulting from one of various infections, of which influenza is perhaps the most notable example, but not *per se* an infectious or contagious disease, though classed as such by our health authorities for various reasons, reasons more practical than scientific.

Again, if the pneumococcus is capable of causing, not only pneumonia but arthritis, meningitis, otitis media, corneal ulcers, and all the other lesions in which it is found, are these not merely less frequent phases of a pneumococcus infection in which the pneumonic form is of more common occurrence?

Some time ago, I had a patient who developed a marked case of influenza, a broncho-pneumonia chiefly of the *left* lung, then in rapid succession an acute nephritis, a gastritis, an ileocolitis, a jaundice and a *right* pleuro-pneumonia from which latter she died. Each of these complications cleared up before the next one set in, the infection of the grip attacking these various organs seriatim. They represented a variety of conditions resulting from one general infection rather than a series of distinct diseases. So long as we treat pneumonia rather than the underlying condition, just so long shall our treatment remain an illogical hodge-podge of empiricism

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with its present excessive mortality, due largely to muddy thinking.

If I believed that the pneumonic state is uninfluenced by medical treatment, I would feel compelled to turn my patients over to the Christian Scientist, to an All-wise Providence, or to both, if by any possibility they could be conceived as working in harmony.

Can it be cut short, aborted? Now the battle is on. To those of us who maintain that pneumonia can frequently be aborted and cite case after case where a sharp chill is followed by a high fever, pain in the side, rapid respiration, the characteristic cough, marked increase in the pulse rate, and the customary chest signs, yet under treatment are practically convalescent in from twenty-four to forty-eight hours, the eminent scientist has a stereotyped answer. I always know before-hand what he will say. *Error in diagnosis*. What we really had was a mere congestion. It is sprightly and effective, not to say a trifle dogmatic or a bit discourteous. We are promptly put where we properly belong, in that large class of doubtless well-meaning but utterly incompetent practitioners. How can we argue the matter? As well try to hit a nominative case with a club. We are ruled out of court, have no ground left to stand upon. Post-mortem records show no abortive cases but a superabundance of those that did not abort, and there is a law against assassinating a few suspicious cases for demonstration purposes. So there we are in the front row of those half-educated and wholly misguided morons who have the gall actually to disagree with an established authority, one who has risen by sheer force of intellect above all human fallibility. Hospital statistics show a mortality of from twenty to thirty per cent. What we had were cases of mere temporary congestion, if any. Error in diagnosis is, like the policeman's billy, always handy and an effective silencer. Now having squirmed becomingly, we will resume.

Many years ago, I had a long series of pneu — pardon me, I mean congestion cases in which a large proportion were

apparently cut short and actually aborted by the use of quinine in full doses together with vigorous and protracted diaphoresis. Further experience has demonstrated its efficacy, and to some extent, defined its limitations. It is still, in my hands, a most effective treatment in grip pneumonias, if seen within the first twenty-four hours. Briefly, I give these cases quinine and Dover's powder. If the Dover's nauseates the patient, I substitute morphine or codeine. I repeat the opiate with quinine every four hours as a rule. Meanwhile, I procure about four bricks, place them in boiling water for a time, remove them, wrap them in dry cloths, place them on either side of the patient, cover him snugly, tuck the blankets about his neck, order him to keep his arms under the clothes, give him all the water he wants, see that the room has good ventilation and sweat him for twenty-four hours *or longer*. The sweat-house of our aborigines served a similar purpose. A hot lemonade with the initial dose of quinine will usually help since it not only promotes perspiration but helps dissolve the quinine. As a rule, I do not physic him too freely. You cannot sweat a patient well when he is having too frequent movements, or has his arms out. I sweat him until the bedding is saturated. I do not permit a change of clothing until they have dried out.

Since the publication of various articles advocating this method, many have tried it, as a rather voluminous correspondence would show. Many report marked success while others have failed. So far as I can analyze the matter, the causes of failure lie in insufficient sweating, in a fear of the depressing effect of the prolonged diaphoresis. Given sufficient water to replace that which is lost through the skin, such fear is without foundation. To sweat them moderately for a few hours, to dry them off and change their clothing and bedding, is useless and discredits the method. Under the opiates the patient is quite comfortable. I recently had a woman of eighty-five with a marked pneumonia and a weak heart of long duration. Her only daughter objected to the

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treatment because "she smelled so sweaty." The objection was not sustained, and on the following day she was out of danger.

There is one warning to be heeded. The temperature should be carefully watched. In a certain proportion of cases, fortunately rare, sweating does not take place, or, even if it does, the temperature may shoot rapidly up to an alarming height, usually accompanied by much nervous disturbance and delirium. Given a hyperpyrexia of this kind, it is imperative that the patient be promptly stripped to the skin and sponged constantly with warm soda and water or diluted alcohol *all over the body*. The patient should be rolled from side to side, using just enough water to keep the skin constantly wet. It is to be remembered that it is not the cooling action of the water, but the rapid surface evaporation which most effectively reduces the temperature. This should be discontinued when the temperature approaches 100° F. In the comparatively few cases which developed this hyperpyrexia, several of which curiously enough occurred in the members of one family, there was no subsequent rise in temperature and the cases went on to uneventful recovery. I had three unexpected deaths in which I attributed the fatal result, correctly or incorrectly, to an unrecognized and untreated hyperpyrexia occurring suddenly in my absence. See paragraph under Influenza.

One must also be constantly on guard against a coincident nephritis, which is frequently overlooked. Daily examinations of the urine should be a routine measure. It is always to be suspected if delirium occurs. Diaphoresis, however, together with free purgation and an appropriate diet, are our best safeguards in prevention and control. This is one bolt that I am trying to rivet.

It is useless to endeavor to abort a pneumonia if the patient is not seen within twenty-four hours of the initial chill. There are exceptions to this rule, but in the main it holds. Moreover, once the disease is well established, a dangerous

hyperpyrexia is more likely to occur under this line of treatment. Diaphoresis should be instituted early to be effective. The method outlined is a simple and easy way of giving a vapor bath. Influenza pneumonia is controlled to a large extent, I have reason to believe, by the quinine, which is as near a specific for influenza as I have yet found. Free diaphoresis counteracts the chill, relieves the internal congestion by bringing the blood to the surface, the volume of the blood is diminished by the water poured out through the skin, much effete matter is thrown off, the remaining toxins are diluted by the water which is given freely by the mouth. More than this, diaphoresis normally acts as an antipyretic. It is one angle of nature's thermostat. We perspire freely in hot weather and the reverse is equally true. I have little sympathy with the maudlin fear of active perspiration. Farmers sweat profusely in the July hayfields. Many febrile conditions terminate in a profuse sweat; pneumonia of the lobar type is a notable example. Much water is needful to replace that lost through the skin. It is easily obtainable, inexpensive, grateful to the patient and beneficent in its effect.

Many cases will not abort. When they are seen early we meet with far greater success. The trouble usually starts at the hilum and the early physical signs are likely to be diminution of voice and breath sounds. When we see cases too late for the treatment outlined we must fall back on general principles. The chief danger is myocardial failure and this is, in my judgment, primarily a right heart failure. The circulatory system is a figure of 8, the upper and smaller loop representing the lesser or pulmonary circuit, the lower and larger loop the general circuit. The right heart, pumping blood through the lungs, is comparatively thin-walled. When this circuit is obstructed, it is here that the strain falls. What proportion of the ensuing right heart failure is due to the obstruction, to simple heart-tire, to acute dilatation, to damming back of blood in the vena cava, to deficient oxidation, to myocardial degeneration from the toxins in the circulation,

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to exhaustion of the cardiac ganglia or to other factors, is as yet undetermined. We are fairly well agreed that, other things being equal, the mortality in pneumonia is directly in proportion to the amount of lung or lungs involved and, in a larger measure, to the amount of arterio-sclerosis present. These are largely mechanical factors. Such things can be studied at the bedside even if not fully understood.

It is not so clear why the plethoric man succumbs so readily to pneumonia while the thin and anaemic school-teacher survives. The psychological element enters here. Patients who have never been ill have the fear of the unknown, that most alarming of fears, to contend with. The one who has survived many previous illnesses is comparatively optimistic. I believe that there is another and more potent factor at work. Anaemia is of great frequency but plethora is seldom mentioned these days; frequently a deficiency in blood, rarely an excess. A one-way pendulum that swings to deficiency, then back to center, is an absurdity on the face of it. A hundred years ago, more was written of plethora than of anaemia. The plethoric case often needs venesection early. The horse that is vainly struggling to draw a heavy load over bad going needs relief from a portion of his load rather than the whip. An overburdened and over-distended right heart needs venesection rather than stimulation.

Again, and to use a similar illustration, if we are driving a horse on a hard and swift journey of some length, it is utterly unwise to put him under the whip at the start. He should be allowed to get his second wind. We are not driving a machine but are dependent upon muscle power. Why not tranquilize the circulation as far as we know how? Why not calm down the over-excited heart and the patient as well?

One winter morning, a friend of mine, a surgeon of note, had to abandon his car on account of the drifts. He procured a livery rig, horse and cutter and, thinking it would be a

novel experience, took his little son with him on his visit. The little chap rode for a mile or two in silence and then suddenly asked, "Papa, how do you put her in low?" when the horse, stimulated by the frosty air, struck her best gait.

Why not put the heart in low and conserve its energy for the time of need. Aconite and the opiates have here a proper place. Some fear that opium will check expectoration. Why tilt at a windmill? Children seldom expectorate but almost invariably pull through a pneumonia, if intelligently treated. Aged people, as a rule, expectorate freely and are prone to succumb. Does this prove anything? It proves, at least, that expectoration is not essential to recovery.

Some cases recover without treatment of any kind. During a protracted snow blockade two years ago I saw a young man who had been very ill for a week. He lived in a remote part of the town which was inaccessible at the time. No doctor could reach him and his people could not get to a telephone. When the roads at length were broken out I found that he had just passed the crisis of the lobar form and was bound to recover. I saw a number of similar instances during this same epidemic.

In cases of cardiac insufficiency from any cause, early digitalization may be indicated but it is seldom now employed as a routine measure. Instead, stimulation is in vogue. If digitalis is needed, it must be remembered that it requires time to secure the action of this remedy and it should be started early enough to be of some avail. In pneumonia, the blood pressure is usually low, the condition being, in some respects, analogous to surgical shock. In the later stages, free stimulation may be needful. I seldom use alcohol save in those addicted to it. Forty-six years ago one lady, a prominent official of the W. C. T. U., urged me to abandon the use of alcohol, even in those who were habitual users. I told her that most of them would die if I withdrew the stimulant to which they had grown accustomed. She countered with the objection that she did not believe in people

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going to meet their Maker with the smell of alcohol in their breath. I punctured her argument, I believe, by suggesting that, so far as I knew, they did not take their breath with them. Where alcohol is clearly indicated, as in these cases, I have no hesitation in pushing it until I get the desired effect. In these alcoholic cases, paraldehyde is often of service, chiefly when they become delirious.

It has been repeatedly stated that nephritis is a rare complication. I take issue with this statement. I find it of fairly common occurrence, especially in grip-pneumonias. I believe it often is unrecognized. I make it a rule to examine the urine from day to day.

Three bad symptoms are delirium, abdominal distention and cyanosis. For pain and delirium, codeine is often the most satisfactory remedy. If cyanosis is present, morphia is usually contra-indicated, also in the later stages of the disease on account of its depressing action on the respiratory centers. In distention, turpentine clysters, eserine, strychnine and pituitrin, the latter subcutaneously, are of service.

There comes a time, in the later stages of pneumonia, when cyanosis is prone to develop. If acidosis is present, alkalies are of service. Oxygen, if available, serves a good purpose, but venesection may be required and this not necessarily in the plethoric cases solely. When cyanosis develops, many physicians make it a rule to warn the friends that the end is approaching. Cyanosis usually develops on the fifth or sixth day. Even a temporary relief will often tide the patient over the critical period. The "swelling of the veins of the hands," which long ago Trousseau noted as dangerous, may occur. The vena cavae become distended, the right heart choked and dilated, the sound over the pulmonary valve is indistinct, the blueness of the lips and finger-nails increases, a rattle appears in the chest.

Here, failure to appreciate the condition and relieve it by bleeding seems to me little less than criminal. I bleed until the congestion under the nails is perceptibly dimin-

ished, then resort to stimulants. The right heart, relieved of its load, able once more to approximate its valves, again takes up its work and the danger is thereby lessened. The pneumonia is not cured, but the pressure is relieved at the weak point. Here a small, weak pulse is not necessarily a contra-indication. The lesser circuit being obstructed, it necessarily follows that the left ventricle and the arteries are comparatively empty. I have seen a weak and fluttering pulse come up strong and full while blood was still flowing from the arm. The explanation seems obvious.

In these cases, adrenalin is of some service. Atropine will check the rattly oedema, but does not relieve the failing right heart, and the patient dies. Oxygen is of much value, but does not reach the real trouble, which is more than a defective oxygenation. In pleurisy, with extensive effusion, the function of one lung may be entirely abolished, the other lung seriously compressed, the heart action markedly interfered with, yet oxygen is seldom called for. Cyanosis seldom occurs.

Some elderly patients with weak hearts do better if not put to bed at all. I have treated many of these cases, in which orthopnoea was a feature, in an easy chair. With a headrest arranged in front of them, they can sleep comfortably. One woman with a double pneumonia, I delivered of a ten-pound baby while she was sitting in a morris chair, on the fifth day of her pneumonia. She was able to lie down after labor was completed, and made a nice recovery. It is not always wise to tell some of these patients that they have pneumonia.

Pneumonia is a disease of short duration and I avoid overfeeding, but in country practice and in the absence of a capable nurse it is difficult to strike the right note. I came near losing one case through underfeeding as is elsewhere noted. I know that I lost two cases from overfeeding. It seems to be a human failing to attach more importance to the giving of medicine than to other more essential measures. My

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cases averaged a fraction over five days of acute illness and in that length of time they are not likely to starve. These cases included those which were aborted and those which ran overtime. The latter were usually double pneumonias or those of pleuro-pneumonia with a good deal of effusion. Some had purulent infiltration which delayed progress and raised the average materially.

I use poultices occasionally for the relief of pain, not otherwise, since the constant changing of poultices disturbs the patient and I am convinced that they are of little service. Fresh air is beneficial to all of us and is a necessity when one's lungs are filled with an exudate. I can see only one advantage in sealing up a sick room. It makes the air just that much better for those who live outside the room.

One old woman made Dr. Jenkins trouble by her continual insistence on a stuffy sickroom and the use of poultices. Finally one day she recounted the marvellous results she had witnessed from the timely use of a cow-manure poultice. Jenkins listened attentively, then said, "Madam, it is a matter of great regret to me that we have not always seen eye to eye on this matter of poultices, but, in this instance, I am happy in being able to say that the old-fashioned barnyard poultice seems to possess some decided advantages over any other with which I am familiar."

"In what respect?" she asked.

"In two respects. In the first place, if you watch your chance, you can get it already warmed, and in the second place, it is a blamed sight cheaper. I bid you good morning."

When a child has pneumonia, the mother is seldom content unless poultices or some similar applications are used. I often use a mixture of camphor gum, one ounce; oil of hemlock-spruce, one ounce; and kerosene or some bland oil to make four ounces. If I need an active counter-irritant I use oil of mustard or croton oil in a similar mixture. This I direct to be rubbed into the chest, front and back, every three or four hours. It is inexpensive, not unpleasant to use and takes

the place of various patent rubs. I am satisfied that it does a lot of good — to the rubber, if not the rubbee.

In children, prolonged diaphoresis is difficult to secure and maintain. They do not submit tamely, do not bear opiates well and object strenuously to quinine. They are not arteriosclerotic, seldom have weak hearts, and rest in bed together with good nursing is about all that they need. For many years past, I have had practically no mortality from this disease in children. I usually give aconite in small doses and avoid the coal-tar derivatives as I would Mephistopheles the Magnificent and all his legionnaires.

The people who develop pneumonia are not those who are exposed to our fierce northern winds and our bitter cold. Not the lumberman and the ice-cutter but the old man who smokes all day while sitting over a hot-air register, the old grand-dame who knits by the kitchen stove and the child who is still too immature to go to school or play in the front yard snow by himself. Of such, pneumonia takes its annual toll. Other predisposing causes are: debility, drafts, acute infections, inhalation of dust and other irritants, and the common cold.

The current classification of pneumonia is from a bacteriological standpoint. Type I is due to pneumococcus infection. This is usually mild with a rather low mortality. Types II and III are due to other strains, while Type IV, comprising some twenty different varieties of infections is, obviously, a heterogeneous assemblage of leftovers. This classification will likely undergo modification before long. To me it seems the first real start in the right direction in that it has a scientific basis. It is an admission, by implication, at least, that there may be truth in my contention of many years, that pneumonia is not a disease but merely one manifestation of various infections and diseases of diverse character. It is not of great practical service to country practitioners who are not able to get laboratory reports in time to make them available.

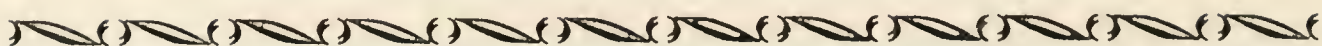
In my more or less humble opinion, the present high mor-

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tality is an indication of something radically wrong in the management of so prevalent a "disease." I feel under no constraint to consider it a self-limited disease and helplessly to stand by and allow it to run its course under all circumstances and conditions. The view that pneumonia is a diagnosis, sufficient unto itself, for a group of pulmonary consolidations due to diverse etiological factors and having no common denominator, seems a medieval absurdity. I know of no medical problem more worthy of intense and unbiased study and research. At present we are prescribing supposititious remedies for an alleged disease—when we treat it by the customary methods. I speak bluntly, for this pneumonia problem needs sledging. Life is real, life is earnest, we are told, but some of us spend too much time in avoiding both these facts.

It is high time for some of us birds to lay an egg. While I admit that the term "pneumonia" may have certain advantages to Board of Health authorities and their statisticians, may be a convenience as a general descriptive term in the present state of our knowledge, its use as the name of a *disease* indicates a total paralysis of coherent thinking.

The differentiation of lobar and broncho-pneumonia is at times difficult not only to the clinician but to the pathologist as well. It is of lesser importance than the recognition of the causative factor or factors and this, in turn, is no easy matter since the number of "types" of pneumonia is increasing daily. A good working rule is that the patient who is "threatened" with pneumonia already has it.

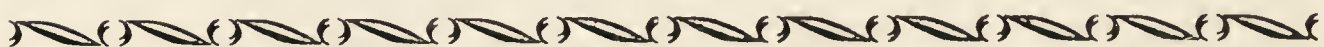


XLVII

PLEURISY

"There is a purpose in pain,
Otherwise it were devilish."

LUCILE



IN 1891 I had a series of cases of acute articular rheumatism in which pleurisy was such a frequent complication that it aroused my interest. Consultation of such authorities as were available at the time led me to believe that, although rheumatism was mentioned by some as a possible cause of pleurisy, most medical authorities failed to attach any special importance to it as an etiological factor, the trend of opinion being that most pleurisies were of tubercular origin, a view which still holds good.

For a period of years I kept a record, including wet and dry pleurisies as they occurred in the regular routine of my practice, and I was forced to the conclusion that what is called rheumatism deserved a far more prominent place in its causation than it had hitherto been accorded. I published my observation on this point in the *New York Medical Record* of September 22, 1894.

Pleurisy, per se, is not attended with any appreciable mortality. When it occurs as the starting point or as a complication of tuberculosis, in connection with the exanthemata, grave cardiac conditions, nephritis, pneumonia, chronic alcoholism and similar serious disorders, it may naturally tip the scales unfavorably, but the natural tendency, in uncomplicated cases, is toward eventual recovery, under almost any form of treatment, in so far as the pleurisy is concerned; this recovery is, not infrequently, tedious and protracted but is, in the main, true.

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It may be well to compare pleuritic inflammation with that of the synovial membranes in articular rheumatism. Gray says that the "synovial membrane resembles the serous membranes in structure but differs in the nature of its secretion, which is thick, viscid and glairy." This is a difference in degree rather than in kind. In a motor car, we do not use the same lubricant on the timer, the piston and heavy bearings. The pleura is a serous membrane, a gliding joint, an enlarged bursa, if you will, between the lung and the chest wall, its function being to allow free movement between the two. The pericardium is an analogous structure. In other words, they are modified joints and the lubricant used is one properly adapted to the requirements.

Pleurisy may be acute, subacute, chronic. Likewise a synovitis. It may throw out serum, fibrin, pus, new connective tissue; may be wet, dry, suppurative or adhesive; likewise a synovitis. Practically all authorities recognize rheumatism as the predominant factor in pericarditis, yet the weight of opinion seems to be that, in the pleural sac, tuberculosis is by heavy odds the chief factor. Up to the time that I published my views in the early '90s, I could not find rheumatism mentioned in the textbooks then at my disposal. I have no quarrel with those who maintain that here tuberculosis, like the famous Abou, leads all the rest; merely with those who fail to mention the second commonest cause. It is the part of wisdom to take the influence of all possible factors into consideration. To maintain that practically all sero-fibrinous pleurisies are tuberculous is too large an order. Generalities are seldom if ever fully true. In this matter I am from the extreme western border of Missouri.

Years ago, while exclusively engaged in hospital work, I treated cases of synovitis of the knee joint with effusion, chiefly traumatic cases, by aspiration, plaster splints and the customary surgical methods then in vogue. Later, when I saw precisely similar cases being treated on the medical side with the salicylates and other rheumatic remedies and re-

monstrated, my attention was called to the rheumatic history of most of these cases. I had been finding what I had been looking for, a traumatism. They had found what their training and bent of mind taught them to look for. Neither of the two schools of thought had seen the other side of the picture. We had overlooked or ignored essential factors.

We all know that many a man severely strains his knee joint but has no synovitis or arthritis following the injury. Given a rheumatic tendency plus a sprain and he is lucky if he escapes. So with pleurisy occurring in the rheumatic, the syphilitic or the tuberculous subject, or in the man who breaks a rib. There is so commonly more than one causative factor at work. It may be added that I frequently find a moderate pleural effusion, occurring during the course of a rheumatic fever, which has been entirely overlooked. In the milder cases, cough and dyspnoea being absent, pain in a rheumatic case would likely be dismissed as incidental. I am convinced that many moderate effusions of this type are never recognized and go on to a good recovery under the systemic treatment for rheumatism which they are receiving.

In the treatment of pleurisy I follow the same line that I do in rheumatism. My chief reliance is on the salicylates, given in full doses at short intervals, until the characteristic head symptoms are fully evident, after that, in sufficient doses to maintain this effect. I use potassium iodide, the alkalies, colchicum or other remedies when indicated and tonics in most cases to counteract the tendency to tuberculosis. In a large majority of my cases I have not found it necessary to aspirate though it is a simple and harmless procedure. Within limits, the effusion is not productive of harm, on the contrary, it keeps the inflamed surfaces apart during the movements of respiration. When the fluid is found at a high level, when the apex beat is displaced, when it is not absorbed within a short time, or in the early stage to prove a diagnosis, the aspirator is usually indicated. Treated purely as a rheumatic manifestation, I have seen large pleural effu-

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sions disappear in two or three days. The average duration of my tabulated cases was a little over six days. One lasted twenty-three days.

This young woman had a real intolerance of the salicylates. When she could take the remedy the fluid subsided rapidly. When it was discontinued the level of the fluid rose rapidly. This occurred so repeatedly that it was convincing evidence of the influence of the salicylates. Knowing what I believe I now know, I would put such a case on the iodides, preferably the syrup of the iodide of iron. At any rate, this was thirty-four years ago and she is still in excellent health.

This general plan of treatment is effective in wet or dry pleurisies and very frequently in the pleurisies occurring in tuberculous subjects. Here the pleuritic involvement may be incidental or accidental. Rheumatism has the reputation of "going to the weak spot." In such cases the rule is that the pleurisy is promptly relieved while the phthisis persists which naturally would be anticipated. Looking at pleurisy as a rheumatic involvement in a fairly large percentage of cases, the necessity for fine distinctions between a wet and a dry pleurisy, between pleurodynia, the old-fashioned false pleurisy, myalgia, intercostal neuralgia, between costal, diaphragmatic and pulmonary forms of pleurisy, is not of so much moment. When we have a rheumatic joint we do not treat the synovial membrane of the external lateral ligament or the semilunar cartilages, *per se*. We treat the rheumatism as a whole and the local lesions as indicated.

I am fully convinced that, under all ordinary conditions, this plan of treatment is extremely effective in reducing the effusion, abating the cough, relieving the pain and getting the patient once more in working trim. I have not arrived at this conclusion hastily like the man who, after describing with great gusto his enjoyment of a ten-course dinner with seven different wines and liqueurs, topped off by dark and murky Havanas, said, "But like a blamed fool, I drank a glass of cold water just before retiring and this morning I

woke up with an awful headache. I've learned one thing. A man is a perfect fool to drink water just before going to bed."

Compare this line of treatment with that of the blisterers, the strappers, or the vis medicatrix nihilists. Any reasonable theory is preferable to vague empiricism or a do-nothing policy — particularly if it does not fade in the wash. I have taken many a rough lick from the tongue of our professional lions but my bones are still intact. Let this stand or fall as it deserves.

Uncle Eph says, "One time my wife thought she had pleurisy, but I thought it was jest a touch of neuralagy in her side. Anyhow, she went to see Doctor Macfie about it. She says to him, 'Doctor, I've got an awful bad pain in my side. It hurts me so when I take a long — Ouch!' and a-grabbin' her side.

"Doc, he says then, 'What in thunder do you want to take a long *ouch* for anyway?' Then he put on one of Mr. Porous's plasters and a tight bandage an' she was all right in a few days."

XLVIII
ASTHMA

THE term asthma is an exceedingly loose one applied to a large number of conditions accompanied by bronchial spasm and wheezing. Many of these affections have little else in common. The obstruction to breathing is much more marked on expiration than inspiration, hence the tendency to emphysema in chronic cases. It may be a vaso-motor neurosis, an allergic manifestation or it may be of cardiac or renal origin. It is frequently of reflex source and, at times, due to acidosis. There are a thousand and one exciting causes in those who are predisposed, of which an ordinary cold or a bronchitis are examples.

It often comes under the domain of a surgical affection. I have seen more complete and permanent cures result from intra-nasal operations than from any other method of treatment. Many of the worst cases which I have encountered have remained free from recurrence for periods ranging from five to thirty-five years, after removal of nasal obstructions and contacts, or drainage of sinuses. Such contacts, due to nasal spurs, deviated septums and turbinal hypertrophies, are potent causes of asthmatic attacks, due probably to reflex action in a large proportion of such cases. I have operated on many of these cases and sent many to nose specialists. Occasionally, when one nasal surgeon failed to relieve the case by operation, another would be entirely successful. This can be readily understood by anyone who has done much nasal surgery.

Rhinology has made great advances in the past decade but the nose, with all its accessory sinuses and cellular cavities, some of which are as yet practically inaccessible, presents

many difficulties which will no doubt be surmounted eventually. I am convinced that new methods, improved instruments and appliances, a better technic, more efficient methods of illumination and inspection and a more accurate knowledge of the anatomical and pathological conditions, will be a natural development. With each improvement it is reasonable to expect not only relief from various focal infections and their sequelae but a large proportion of our asthmatic cases will be permanently cured by removing the cause of the reflex spasm and symptomatic treatment of this class of asthmatics, by internal treatment or by sprays and inhalations, correspondingly lessened.

Nasal abnormalities and deformities are of such common occurrence that we consider almost phenomenal a nose which is symmetrical and normal in every way. Given a narrowed space in the reflex area of the nasal mucous membrane, a turbinate bone encroaching this and covered by an erectile tissue which becomes swollen and congested from various local irritants, from a vaso-motor rhinitis or from general conditions, and a contact results which, in turn, excites reflex action. To remove such contacts, actual or potential, is a more logical line of treatment than the avoidance of some exciting cause or special irritant. Attacks of pain in the epigastric region, due to a chronic appendicitis or a cholelithiasis, do not need gastric sedatives so much as radical surgery.

Asthma, as an allergic reaction or an anaphylactic manifestation in hypersensitives, is so broad a subject that only a few of the high spots can be touched, yet asthma and its congener, hay fever, is so commonly a matter of allergic sensibility that reference must be made to this phase of the matter. Perhaps, as Horace said centuries ago, in laboring to be concise, I may become obscure. Much has been written about the relationship between asthma and hay fever, the latter having as exciting causes the wind-blown pollens, chiefly those of ragweed, timothy, and plantain.

The symptoms of allergy are angioneurotic edema, hives,

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asthma, eczema, migraine from edema of the nerves, edema of the glottis, cerebral edema and a lot of similar manifestations. Exciting causes are rabbit fur, dust from feathers or from cats, horse dandruff, the pollens of various kinds, various dusts, etc. Foods of some types, various proteins, milk, eggs, wheat and its products, strawberries, shellfish may excite troubles in the hypersensitives. Phenolphthalein, aspirin, quinine and a long list of drugs may cause mischief in susceptible people. Insect powder, orris root and many other things may do the same, certain perfumes, for example. It is easy to say that these are merely manifestations of allergic reactions in the hypersensitive. Such high-sounding phrases are begging the question; the older terms, diathesis, dyscrasia and the like had the merit of being almost as vague. The real question at issue is, what is back of these allergic manifestations, what is the common denominator? Merely naming it does not explain.

Change of climate has benefited many asthmatics. Avoidance of the irritants alluded to is needful. Outside of nasal surgery, I have relieved more cases of asthma by means of the iodides than with any other remedy. It is especially beneficial in those who show a tendency to chronic bronchitis or emphysema, on the one hand, or who have allergic sensibility, the iodides likewise relieving their hives, angioneurotic edema, etc., as well. My results with it in the allergic cases may be on account of the same iodine deficiency which is so prevalent here or, and this seems to me far more likely, that the iodides have a beneficial effect on allergic manifestations in general. Where there is a history of eczema in infancy or early childhood, I usually find that Fowler's solution or Donovan's solution, when added to the iodide mixture, is of value. Further light on the basic cause of these allergic conditions is needed and, in this section at least, an iodine deficiency is seemingly a factor of some importance. When it has been demonstrated that there is a definite cause for this hypersensitiveness we will have taken a long step, not only

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in the treatment of asthma but in the underlying allergic manifestations.

Hay fever cases sometimes secure marked freedom from the customary annual attacks through the administration of arsenic for some weeks prior to its anticipated annual recurrence. Here, belladonna is oftentimes a useful adjuvant, as in asthma proper. Some are intolerant of the belladonna. Arsenic is indicated where the skin has a harsh, dry and scaly feel or where there is a definite tendency to eczema or allied affections of the skin. For the relief of asthma, lobelia, grindelia, euphorbia pilulifera and various herbal preparations are of service. Practically every chronic asthmatic is familiar with the use of the asthma powders sold in the pharmacies. The basic ingredient is usually stramonium. To this is added a small amount of saltpeter. The formulas vary but more or less benefit is ordinarily obtained by inhaling the smoke from these compounds. Perhaps adrenalin is, on the whole, the most satisfactory remedy for the immediate relief of the attack, given hypodermically, with prompt effect in the majority of cases. An extract from the posterior lobe of the pituitary is of much help, intramuscularly along with the adrenalin.

Ephedrin acts in a similar way to adrenalin and has one advantage — it can be given orally. It is useful for the chronic asthmatic who lives a long way from the doctor. By having a supply on hand for such emergencies, the patient is more independent and it will save the doctor many a call during the night.

In dealing with asthma we should remember that it is merely a symptom due to one or more of a large number of causative factors. It calls for an open mind and a deliberate review of the general situation.

My friend, Dr. Matthews of Nicholville, called me in consultation to Fort Jackson. It was a long ride and a lovely October day. I will confess that I loitered a little on the way gathering beechnuts under the big trees by the wayside,

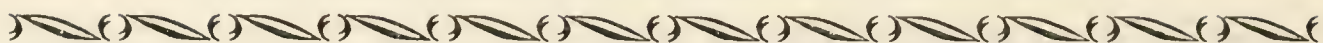
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nevertheless I arrived ahead of the worthy doctor, parking my car in the patient's yard. He arrived shortly after, shaking my hand in his hearty manner, and inquiring as to my health. I replied, "I'm all right, but I have my opinion of anyone who drives a Ford car."

"What's the matter with a Ford car? It suits me all right. I can get there and back again at a small expense and can get it repaired easily anywhere. If I can have a new Ford every two or three years, I'm satisfied. Why are people always kicking about Fords? S-a-ay! Isn't that a Ford you're driving, yourself?"

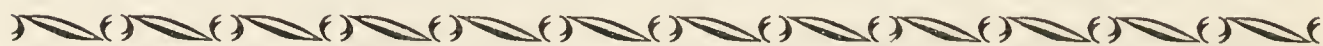
"Sure it is, Matthews. For years I have endeavored to curb your tendency to jump at conclusions. You're too hasty, too impulsive. What I was about to say when you so rudely interrupted me, was this. I have my opinion that any man who drives a Ford car is a shrewd, sensible and level-headed man. Now you've spoiled it all. Let this be a lesson to you in the future to be more deliberate in your judgments."

In the treatment of asthma, hay fever and similar conditions one should not arrive too hastily at the conclusion that they are solely due to rabbit fur or ragweed pollen, to the exclusion of underlying factors. The pet canary should not be needlessly sacrificed.



XLIX

CARDIAC DISEASES



ON account of some slight ailment, a blacksmith came into my office one afternoon and, after taking his pulse and looking at his tongue, I put a thermometer under his arm. Before his temperature could be registered, he turned pale and begged me to remove it because his "heart was too weak to stand that thing."

Owing to the complex innervation of the heart, a large variety of conditions, often through reflex action, may cause various cardiac symptoms, from palpitation to heart block. To prescribe ten-drop doses of digital three times a day is too often the refuge of the slothful mind. In many cases, aconite is indicated rather than digitalis. Ammonium bromide is far more beneficent in its action than cardiac stimulants in a large proportion of the cases which complain of "heart trouble." The ammonium salt is preferable to the potassium here, being less depressing if given continuously. Digitalis is a valuable and, in proper cases, an indispensable remedy but one frequently abused. In auricular fibrillation, dilation and failing heart due to valvular disease, it is of little avail to give digitalis unless the patient is put to bed and kept there for some weeks or perhaps months.

The heart is a muscular pump which must work ceaselessly if not endlessly. It is useless to whip an exhausted horse unless it be to get him across some obstruction or, better, to enable him to reach the stable where he can secure food and rest. In failing compensation we must seek relief for the heart in three ways, to ease the burden on the heart, to secure rest for it, in so far as we can, and to feed it up. The burden is lightened by the relief of excessive arterial tension. If there

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is much venous congestion and stasis, free venesection will help unload. Here is a legitimate field of endeavor if tempered by wisdom and good judgment.

The second indication, to secure rest for the heart, requires rest in bed. Some patients with cardiac trouble cannot lie down but they can attain recumbency in a measure. Since absolute rest for the heart is unattainable, we can at least shift into low gear. The heart must lift so many ounces of blood so many times per minute if we are to continue to play golf or even backgammon. Just how many ounces or tons it must lift in a day or in a lifetime we will leave to those mathematically inclined. Statistics are frequently mere figures which cumber the machine of thought. Tossing a pail of water in the air to a height of five or six feet about seventy times a minute is a far heavier task than sloshing the same amount to and fro in a level horse-trough. This is a homely illustration but some of us run-of-the-mine doctors may be as homely as the illustrations. Recumbency is one of the essentials.

The third indication is to feed the heart. Iron is a food for the cardiac muscle. Horsemen who have wisdom rely more on "short oats" than the "long oats," the latter phrase applying to the use of the whip. Electrocardiograms throw light on the cardiac picture but, even without such aid, we can ease the load, rest the heart, feed it up. In many cases we can do little more, regardless of what tracings may show. Digitalis by all means, when it is indicated, but not as a routine procedure. Judicious and carefully regulated exercise, once compensation is established and the heart has recovered its tone. We will do well to remember that overstrain will weaken the muscles of an arm, necessitating its disuse for a time, possibly. Wearing an arm in a sling for a long period will likewise weaken the muscles. Judicious exercise strengthens the muscles of the arm. There is another nice field here for the exercise of judgment; we must learn to choose with such wisdom as is allotted to us.

Thirty years or so ago I had a punctured tire. I applied a

patch and laid the moderately inflated inner tube in the sun to cure. My attention was caught by a symmetrical swelling in a part of the tube which was inflating, cobra fashion. It increased in size, slowly at first, then with increasing rapidity until I realized that it was about to burst and I released the valve just in time to save a modicum of my ill-gotten gains. Due to some defect in manufacture, the tube was not of uniform thickness and the expansion of the confined air, from the heat of the sun, naturally ballooned out the thinnest and least resistant portion of the tube. The thinner the weak part of the tube became, the less resistance it offered; a vicious cycle was established. It seemed to me that it was a graphic illustration of what may occur in cardiac dilation and aneurism, for instance. This incident clarified my ideas to some extent.

In giving directions to some of my cardiac cases, I boil them down to one plain and simple rule which they can comprehend and remember, one which will cover a lot of contingencies which cannot be foreseen. Any exertion, any excitement, any overloading of the stomach, any overstrain of any sort, which causes shortness of breath, is harmful. Anything which *does not* cause this is ordinarily permissible. Admittedly, this is a rule of thumb but of broad application, easily memorized and therefore satisfactory.

In cardiac dyspnoea with pulmonary edema, a hypodermic of atropine and morphine has been very serviceable. In acute heart failure, as in surgical shock of certain types, morphia gives prompt relief. In some forms of surgical shock, it is tolerated in large doses. I recall one hospital case of avulsion of the arm at the shoulder; a young and robust man with the axillary artery hanging out of the wound. The pulsations were slow, the cardiac systole prolonged, a condition of cardiac spasm. Such conditions are shown in the laboratory when the foot of a frog is crushed. I considered it a case of shock. The operator said that he could have no shock with such a slow and full pulse. He amputated the shoulder without delay, at

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4 P. M. The patient did not rally. Pulse 130, weak and thready. Temperature rising. He was given digitalis, strophanthus, strychnia, ether, ammonia, brandy, external heat, all the customary remedies. He grew steadily worse, his pulse became imperceptible, palpable only in the carotids, running about 160. Temperature 104°.

At 9 P. M. the radial artery of his remaining arm was opened with some difficulty as there was no pulsation and it resembled a tendon. A large saline transfusion was made, the operator still insisting that his condition was the result of excessive blood loss. At 10:30 he said, "Treat him for shock or what you will; he is about dead," and went home. He then had a temperature of 105° and the carotid pulse could not be found. I gave him a hypodermic of morphia, one half grain every fifteen minutes until he had a total of three and a half grains. His temperature dropped, his pulse came back, he was not narcotized materially, and at 2 A. M. he sat up in bed and demanded snuff, to which he was addicted. "What next?" as the frog asked when his tail fell off. He made an uneventful recovery. Nothing more.

In auricular fibrillation, where the heart action is exceedingly rapid and irregular, quinidine seems to be the best remedy. Many patients have purely functional disturbances of the heart action and need reassurance as much as medicine. It is useless to attempt explanations of the action of the sympathetic, of the bundle of Hiss, to explain on anatomic grounds how nerves or a reflex from other organs can cause palpitation and irregularity. They *are* able to understand the application of a local happening and may be comforted thereby. The following story applies.

Many years ago, when I was a drugstore apprentice, the local butcher had a shop adjoining the pharmacy. He had a handsome black stallion, well broken but high-strung and nervous, hitched to his butcher cart and standing in front of his shop. The horse became unmanageable one morning. He reared, tried to get into the butcher shop and misbehaved

generally. The butcher, Ora Braddock, was holding him by the bridle and trying to quiet him and a crowd quickly collected. Our liveryman, Rod Bissell, said, "Ora, that hoss has the bots. Give him an ounce of chloroform in some gin and water and it will settle them bots for a while."

Dr. Williams came along and said, "That horse has flatulent indigestion and what he needs is four ounces of hyposulphite of soda in a quart of water to dispel the wind on his stomach."

Dr. Daniels arrived and said, "Ora, that horse has inflammation of the bowels. The best thing to do is to put a boy on his back and ride him down into Noble's pond and keep him up to his neck in the water for about an hour. That will cool down the inflammation better than anything."

Wash O'Ryan, the local veterinary, came along. He said, "That horse has the colic. He needs three ounces of sweet spirits of nitre and an ounce and a half of laudanum and he needs it mighty quick."

Si Perkins was driving by with a load of milk cans and he said, "Ora, if that's the hoss you bought from Hennery Kelly, he'll get over it all right. I've seen him have them spells lots of times."

Rod Bissell, who had a peppery temper, again spoke up, "Ora, don't stand there like a blamed sap a-holding that there hoss by the nozzle. If you don't do something for him alfred quick, he's going to die right on your hands."

Ora looked the crowd over with utter contempt. "You're all a bunch of dum fools! It's only the turpentine I rubbed on his legs to keep the flies off."

The crowd folded their tents and intents like the Arabs and silently stole their various ways. I had sold Ora a half pint of turpentine shortly before this happened and — well, I never was much of a horse-doctor, anyhow. I merely look like one.

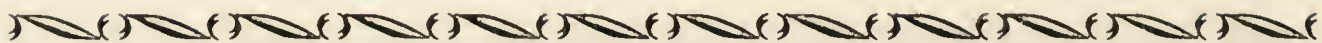
Doctor Jenkins says, "In some ways a heart is like a horse. A horse that kicks and rears and sunfishes and runs away

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must be in fine fettle, but one that is pretty nearly ready for the bone-yard doesn't shy at a squirrel running along a rail fence. He may limp and stumble some but he isn't wasting any energy in prancing 'round."

Some years ago one of our local druggists received a prescription for an infusion of digitalis. He had the leaves in stock but wired his nearest jobber for a quart of "aquae bullientis." The vacuum bottle was then non-existent and he received a return wire. "Have plenty in stock but fear deterioration *en route*. Advise you to substitute a quart of boiling water."

We occasionally meet with a form of cardiac failure where some plethoric bull-necked banker attends a banquet and soon after develops an irregular heart action and collapse. Here digitalis and other cardiac stimulants seem indicated but I hope it is permissible to suggest that the best heart stimulant in this class of cases is a quick-acting emetic. Quite often venesection is urgently needed.

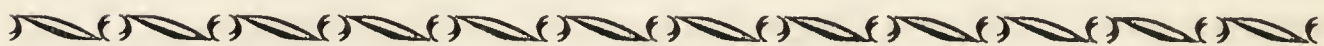


L

ANGINA PECTORIS

“Experience teaches slowly, and at the cost of mistakes.”

FROUDE



THE little daughter of a neighboring physician named her dolly Angina Pectoris, undoubtedly a very lovely name and one clearly showing evidence of parental influence and the effect of environment. Angina Pectoris is a disease of advanced life, though not necessarily confined to the aged. True angina, in the majority of cases, if not in all, is due to degenerative changes in the coronary arteries which supply the musculature of the heart and is simply one of the many phases of arteriosclerosis as a rule. As would be expected, it commonly precedes that even graver trouble, coronary thrombosis and occlusion.

Sclerosis of the aorta and similar conditions are not readily distinguished from angina but the distinction is more academic than practical since the treatment would be much the same in either case. These conditions must not be confounded with attacks of so-called “acute indigestion,” a term which should be thrown into the discard, since it is usually a confession of ignorance of the real cause. The more a man really knows, the less fear he has of saying simply, “I don’t know.” In arterio-sclerotic conditions, cramps in the leg muscles are common and of no serious significance ordinarily, but a single cramp in the heart muscle is quite likely to be fatal. It is not impossible that this may occur since there would be little definite evidence of it at autopsy.

A coronary thrombosis, like angina, is always a very grave malady. It is not necessarily fatal for the thrombosis may be incomplete; a collateral circulation may, to some degree, be

established and it is quite possible that the vessels of Thebesius may assist in maintaining the nutrition of the heart muscle when the coronary arteries are occluded. Such patients make a slow and incomplete recovery and are usually incapable of much exertion.

Angina does not always run true to form, many cases being atypical. The characteristic pain running down the left arm may be slight or entirely absent. In the case of sudden attacks of substernal distress, the possibility of angina should always be considered in a patient at or beyond middle age. In such cases a diagnosis of false angina is hazardous, not only to the patient but to the reputation of the diagnostician. It is wise to be on guard against an unexpected and atypical angina which may result just as seriously as if the patient had all the classical symptoms. Occasionally a patient will die during the first attack, but on autopsy, some of these will show coronary thrombosis. Theodore Roosevelt said, "Two-thirds of wisdom consists in being wise in time," and this was worthy of King Solomon. On the other hand, the innervation of the heart is exceedingly complex. Pressure on a distant button may cause the buzzer to ring steadily or the central office may give you the wrong connection. Wires may get crossed. I have often been aroused from a much needed rest by some late loafer leaning casually against the push-button on my door-jamb. There may be other causes for anginous symptoms than those arising from degenerative changes.

I recall one fatal case resembling angina in some respects. A young woman (as women go these days), apparently in excellent health otherwise, suffered from attacks of "dead finger," most pronounced in the little finger of the left hand. This condition apparently bears some relationship to Raynaud's disease on the one hand and to angio-neurotic edema on the other. It may be an allergic manifestation. They are manifestly directly due to instability of the vaso-motor system. Periodic attacks of cardialgia are not uncommon in some of these conditions. Apparently as well as usual, this patient

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was taken suddenly with a severe pain in the precordial region, while sitting at the breakfast table. She died in a few minutes, long before my arrival, and her husband, who was a man of intelligence, stated that she breathed for some little time after she became pulseless. I was unable to get an autopsy but, had this been possible, it might have thrown little light upon the actual cause of death. It seems reasonable to suppose that an attack of arterial spasm, such as she frequently had in her left little finger, if occurring in the heart muscle, might leave little conclusive post-mortem evidence and yet might readily explain the sudden fatal termination. This is mere conjecture, yet it may be worthy of consideration.

It is commonly stated that there is no cure for angina pectoris; this seems to me too pessimistic a view. When a man says he *knows* no cure, we should take his word for it. When he asserts that there *is* no cure, he leaves the solid ground of fact and steps blithely off into the treacherous bog of personal opinion, and when he confuses opinion with fact, he is lost. We are reminded of the little boy who met the colored woman and called the attention of his uncle to the fact that her face was black. "Yes, Freddie," said his uncle. "Her face is black and her hands are black and, in fact, she is black all over."

The little boy looked up at him in awe and said, "Gosh! Uncle. What a lot you know."

In angina cases I am accustomed to tell my patient that if he does not have a fatal attack within the next few weeks, that is, if I can get sufficient time to secure the full action of the medicine, I can give him a reasonable assurance of recovery. I have had very many angina patients who were pronounced hopeless on most excellent authority, yet who, under what I deemed suitable treatment, made a good recovery, living many years subsequent to this discouraging prognosis; this with entire freedom from these attacks, to die later, perhaps, from some disease or accident which, so far

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as we could tell, was wholly unconnected with the angina.

The steady and persistent administration of potassium or sodium iodide will very frequently give entire relief from these dangerous and agonizing attacks. In some cases it is wise to supplement this with the use of crataegus or English hawthorn. This extract, to be of service, must be fresh and properly prepared. Many makes are wholly inert and useless. I am advertising no man's products, but it is only fair to say that of late years I have insisted on that made by a large pharmaceutical house in Detroit, for the reason that the product of this immense organization has proved entirely satisfactory, while a number of other makes, which I have tried, gave me no results whatever. So far as the treatment of the immediate attack is concerned, I have nothing to add to the well-known virtues of amyl nitrite, sodium nitrite, glonoin and such vasodilators. Various other and newer ones are now under trial.

To be "right up to now" (a Southern localism much more expressive than being "up to date," which may be almost twenty-four hours old) there are quite a few new synthetic remedies for angina, trichlorethylene for instance, that are being used for anginous attacks. Experience will eventually enable us to decide as to the relative merits of these newer agents.

In coronary thrombosis, referred to at the beginning of this chapter, extirpation of the thyroid gland is now a common procedure. This produces myxoedema and slows down things generally, but this in turn is readily controlled by giving thyroid medication.

As regards my attitude that angina pectoris is not necessarily incurable, I fully realize that the diagnosis will be seriously questioned and that it will be claimed that the cases which got well under this line of treatment were syphilitic. The latter hypothesis is wholly untenable for all the evidences and all the tests were entirely negative in nearly every instance. As regards the former, I can only say that the diag-

nosis in many instances was not mine but that of men of large experience and high repute as expert diagnosticians. So that lets me out when, with a cheerful grin, I pass the buck. "Let him that thinketh he standeth take heed lest he fall," is a proverb that applies to all of us. I think that the reader will agree with me that he would like to do something for these sufferers and, since the sufferers are of a like opinion, this makes it unanimous. However, some people still believe the world is flat and it must, indeed, appear so to those physicians who have no faith in medicine.

Speaking of faith reminds me that some thirty years ago, while on a trip to Lake Okeechobee, Florida, after wild turkeys and deer, we camped overnight near an isolated farmhouse. In the early morning the rancher came over to see us and, hearing me addressed as Doctor Macartney, immediately pricked up his ears and told me that a neighbor had been taken with a chill, with a high fever, pain in the side and cough; that on the previous day they had sent a boy on horseback some sixty miles for the nearest doctor at Fort Pierce on the East coast; that they expected him on the following day. Believing that the man had pneumonia and that I might give him temporary assistance, I inquired where the patient lived. His reply was illuminating. "His ranch is about forty miles from here by the trail. If we had only known that a doctor was coming through here today *wouldn't it have been mighty handy!*" What a tribute to the profession! Any kind of a doctor, qualifications wholly unknown, coming within forty miles on the following day would have been right "handy."

LI

STOMATITIS

ONE of the common affections of infancy is thrush. No doubt every practising physician has his favorite remedy. I commonly use three drams of potassium chlorate and three drams of boric acid with a few of Seiler's antiseptic tablets. This is dissolved in a quart of boiling water, set aside in a fruit jar or other container and allowed to cool. Presumably it is no better and no worse than many other agents. After using many of the highly recommended and widely advertised mouth washes without success, I find that I am constantly turning back to this simple but efficient remedy.

I want to put in a word, however, as to the method of use. Unless specific directions are given, the average woman is apt to tie a bit of muslin on the end of a stick, and with this swab, mop out her baby's mouth from time to time without changing it. As the baby nurses to contentment, he is prone to become drowsy and fall asleep and a small amount of milk is left in the baby's mouth which affords an excellent culture medium. For this reason, the appropriate time to wash out the mouth is immediately after feeding. The mother commonly objects to this on the ground that she does not wish to disturb the baby after he has fallen asleep, but this is hardly a valid objection, since I find that the baby is little disturbed by this, as a rule.

I direct the mother to cut some clean muslin, preferably something old and soft, into pieces about four inches square. These are put in a package and sterilized by dry heat in the oven. After each feeding, an appropriate amount of the solution is poured into a sterile saucer or plate, the bulk of the solution being kept in the original container to avoid contam-

ination. One of the muslin squares is dropped into the solution in the saucer, then wrapped around the mother's finger, the infant's mouth is gone over gently but thoroughly, the mop discarded and a fresh one used until the toilet of the mouth is complete. To wipe out either an infant's mouth or an eye with a stick is absurd.

Ulcerative stomatitis is a more serious affection. Such ulcers must be carefully distinguished from mucous patches. When these mouth ulcers are few in number and accessible, touching them once, lightly, with the "mild" or half-strength nitrate of silver stick is usually all that is required. This immediately relieves the soreness, forms a protective film and the ulcers heal rapidly. Chronic and rebellious cases are due to some dyscrasia. The administration of chlorate of potassium with a change to a proper diet will be required. Stomatitis is not confined to the mouth by any means. It may extend to the oesophagus, stomach and bowels. It may even reverse this process, in which case the diagnosis may be difficult.

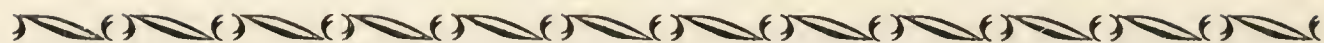
When my oldest daughter was about a year old, she had a severe and intractable colitis. This was followed in turn by an enteritis and, later, by a gastritis, all of which proved resistant to any treatment which various consultants were able to suggest. She developed extreme prostration after some weeks and to add to our difficulties, after continuous diarrhoea and vomiting, she developed an acute oesophagitis and was unable to swallow anything, the fluids regurgitating at every attempt. By this time I had more than a suspicion of what was the trouble but she was pulseless and we were in despair. This was nearly thirty years ago before the vitamins had burst into full bloom. Feeling that if we could keep her alive until the process reached her mouth she might still recover, I used a large catheter and funnel as a stomach tube and fed her peptonized milk at two-hour intervals. With each feeding we could see her color and pulse slowly returning. In five days of this tube-feeding her oesophagitis had visibly improved and she was able to swallow her food comfortably but she had

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a well-developed stomatitis of an ulcerative nature. Had we been able to make a proper diagnosis in the early stage, I would have put her on a very different treatment, she would have been spared a lot of suffering and extreme danger and we would have avoided a long period of heartrending anxiety. Meanwhile, I had been seeking a sign and no sign had been given me.

A nurse, on returning from her vacation, gave a glowing description of a dog which her brother had just purchased. On being asked what breed he was, she replied, "I think he is a poinsetta."

It is now the fashion to call these cases of stomatitis, in all its various forms, trench mouth. Just how babies get a trench mouth I am unable to explain.



LII

NURSING SORE MOUTH



WEANING is of course the most effective remedy for nursing sore mouth, but what about the baby? Considering that a similar mouth condition not infrequently occurs during pregnancy and that it seldom or never occurs in those patients who consume milk freely, the natural inference is that nursing sore mouth is a deficiency manifestation akin to the dental decay which is so common with pregnant women. See chapter on Bone Meal.

Repeated observation over a long period of years has demonstrated to my entire satisfaction that if the patient can be induced to take milk in sufficient quantity, the most obstinate and resistant cases of nursing sore mouth will yield promptly to this simple remedy and the general condition of the patient will steadily improve. In some cases as much as two quarts of fresh, rich milk is required and lesser amounts will not suffice. I have repeatedly seen the sore mouth return when the milk was for any reason stopped.

In the absence of laboratory investigation, I will not venture to say just what essential is lacking in the mother's diet or just what nutritive element is supplied by the fresh milk. It may be fat, milk sugar, albumin, casein, one of the various mineral elements. The chemical constituents of milk are numerous, its chemistry not yet fully understood. If I were to hazard a guess and have not mislaid my logic, I would think that a vitamin deficiency is at the root of the trouble and that this lack is supplied by the milk. Women with nursing sore mouth appear undernourished and seriously depressed, and look like Einstein's Theory after a bad night.

I have found this same line of treatment of excellent

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service, likely for the same reason, in the dizziness, faintness, palpitation, nervousness and insomnia from which many women suffer during the nursing period, and likewise in the peculiar insanity which we occasionally see during the time of lactation.

The chief difficulty which I encounter is in persuading the patient to take a sufficient amount of milk. She tells you that she doesn't *like* milk. People are taught by their doctors and their trained nurses to obey orders, by their parents to pick and choose, therefore they swallow nauseous doses patiently and rebel whole-heartedly at good wholesome food, a sad commentary on the way we raise our children. Don't like nice, clean, sweet, wholesome, appetizing milk! They liked it when they were babies, before they got prejudiced in some way against it. Babies are the only unprejudiced people on earth, unless it is the utter fools. Prejudices are things to be overcome, not nestled to our bosoms like the vipers which they are. We all have our pet prejudices but that is nothing to be proud of or to cultivate. We should strive a little harder to like things and to like people that we *should* like. Do we imagine that we can go through life doing only those things that we *like* to do? Is this any valid reason for abstaining from milk when good health or perhaps a life is at stake?

But the mother says that milk does not agree with her. Did it disagree with her when she was a baby, when she was on an exclusive milk diet during the course of that continued fever? Fresh, warm milk, taken slowly on an empty stomach, seldom disagrees. If it does, lime water will usually correct this. That is the way the All-wise provides it, the way the baby or the calf gets it, a little at a time, warm and sterile. The presumption is, if presumption it be, that this was the Divine intention.

Put milk in large gulps, cold, in a stomach containing the sour remnants of the previous meal which, perhaps, consisted of pickled pig's feet, chow-chow, and bric-a-brac

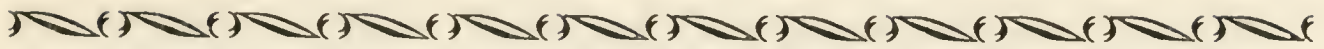
in general, or in a milkpan which has not been cleaned and scalded, and of course it will sour and curdle. If you must mix it, mix it with brains, like the famous painter did with his pigments. Talk about a pain in the neck! I've got one. Centuries ago Horace wrote, "Unless the vessel be pure, whatever you put in will turn sour."

There. I'm through scolding — for the present at least.

We hear much of the emphasis of understatement but overstatement may have its good points in arousing the combative instinct in people, forcing them to think, to indulge in critical analysis which is good for their souls. A good scrap with an eager opponent brings out new angles. It is an intellectual stimulant.

At a society meeting, I recall having a hot argument with a noted specialist which lasted for some time. After the meeting closed, some of my medical friends expressed their enjoyment of the tilt and intimated that Professor Blank had not realized just what he had been up against. I laughed and said that Professor Blank; not only was one of my dearest and oldest friends, but I was sure he had enjoyed the bout to the limit.

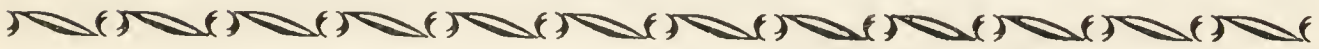
Of one thing I am quite certain. If either of us felt that he had been worsted, we would have adopted the idea of the old farmer whose pet collie had been badly mauled by a Great Dane. After separating the dogs he remarked cheerfully, "Well, I don't see much to do but to take that there pup home and have Maria crochet a new ear on him."



LIII

DIZZINESS AND CHOLELITHIASIS

“The world went round and round and round,
And up in a scrub-oak tree
A cussed jaybird sat and sang
‘My Country, ’Tis of Thee’.”



I HAVE a work in my library which devotes eleven pages to the consideration of vertigo or dizziness. Not that this is too much space, for much more might be said or written, chiefly in regard to what we do not know about this symptom, but in the various forms of vertigo written up there is one brief paragraph stating that it may be due to gastric or hepatic disturbance, which seems rather inadequate. I think we all know that a good dose of calomel followed by a brisk saline cathartic will relieve about 95 percent of the cases of vertigo as we ordinarily encounter them in practice. We hear of kidney insufficiency and the term is expressive of a lack of reserve power the kidneys should normally possess. There likely is such a thing as hepatic insufficiency as well; it is doubtless as good a term as to say that one has a lazy or torpid liver, or to refer vaguely to gastro-hepatic disorders.

Ordinary vertigo, the common or garden variety, is a toxic manifestation due in large measure to constipation and allied conditions. The remedy is to remove the auto-toxaemia and this is accomplished quite well by the use of calomel or the compound cathartic pills of the U. S. Pharmacopoeia. In chronic cases, small doses of bichloride of mercury have a good effect. Hard cooked eggs or sweet milk have a tendency to bring on this vertigo in susceptible people. We often hear of vertigo due to eye-strain. In an extensive eye practice I have seldom encountered it.

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Another cause commonly assigned is arterio-sclerosis. I question if the sclerotic condition has as much to do with it as the general slowing up of digestion and elimination accompanying the arterio-sclerotic condition. Many other things may cause vertigo, aside from toxæmia, those which produce temporary cerebral anaemia, for instance. For the vertigo due to cerebellar troubles, to Meniere's disease and to other special conditions, the reader is referred to special treatises on these subjects, my remarks being confined to the usual forms of dizziness.

Dizziness which comes on when one is getting out of bed in the morning is commonly due to cerebral anaemia.

One day I heard old Ebenezer Hollenbeck telling the assembled multitude in the grocery store how he had doctored with every doctor 'round this neck of the woods and not a danged one had cyored him. He mentioned my name among the rest as one of the failures. I was in no position to deny this so I discreetly withdrew. The only time I ever saw him professionally was one afternoon when I was in a rush to a maternity case, one of those women who do not dawdle and dally about such matters. Ebenezer saw my rig coming and, dropping his hoe, ran to the rail fence and hailed me.

"Doc, have ye got anything that is good fer dizziness?" I handed him six compound cathartic pills without getting out of my buggy, and hurried on.

In cholelithiasis, I have had some apparently remarkable results from the prolonged administration of olive oil. There are cases of severe gallstone colic in people of advanced senility, or those with grave heart lesions where a gallstone operation would entail the greatest hazard. It is in just this class of cases that olive oil is worthy of trial. It is wholly unreasonable to suppose, of course, that where there is a single large gallstone, we should expect relief from such a source, but in those cases where there are numerous small concretions instead of large and hard formations, results may be

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anticipated which will be highly satisfactory. It is often impossible to determine this even with the aid of the modern X-ray technic, but in the class of cases under discussion, it is worth an experimental trial. Our mission, as I take it, is not only to cure people but to relieve suffering as well as to postpone death. Many of these cases suffer excruciatingly, and this procedure has repeatedly afforded entire immunity from further attacks.

I have known of many cases which were helped and apparently cured by some of the various tablets containing bile salts. Two cases of marked jaundice due to impaction of a stone in the common duct were entirely relieved after a period of vomiting brought about by emetics. In each case, they were in sore straits, and for reasons which need not here be entered into, operation was out of the question.

Nothing that I have here said should be construed as opposing in any way operative procedure on the gallbladder or its ducts. For the relief of the terrible and agonizing pain of a gallstone colic, chloroform is indicated, if it is considered safe, until such time as a hypodermic has had opportunity to take effect. A combination of hyoscine or scopolamine with morphine is much more efficient than the morphia alone in relieving this kind of pain, being equally effective in renal colic. It may be well to recall that gastric pain may not only be due to an impacted gallstone or an appendicitis, a perforated peptic ulcer, an attack of acute pancreatitis, or other local trouble, but it may be due to Pott's disease of the spine, to eclampsia, the gastric crises of locomotor ataxia, to lead colic, or to one of many other conditions not directly connected with the stomach or digestive organs. Only passing mention need be made of the lesser forms of temporary pains, such as my friend Nick referred to when he told me, "Last night I had kind of little colics." His colics evidently came in coveys.

Cases of chronic cholelithiasis or of chronic cholecystitis are prone to suffer from sour stomach and most of these

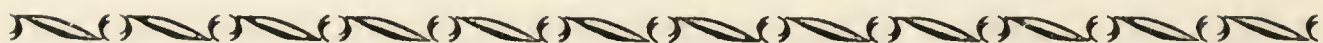
cases are habitual takers of bicarbonate of soda. I am often asked if this does not injure the stomach. It appears to me to be the lesser of the two evils; that taken in small doses until relief is obtained, it is far less injurious than to allow the stomach to remain sour. Most acids are caustic in a greater or less degree. The same is true of most alkalis. Hydrochloric acid is used by veterinarians for removing warts on horses. Soda, in the form of caustic soda, will destroy animal tissue very rapidly; in the form of bicarbonate, it is a very mild solvent of organic material. Combined so that they neutralize each other, we get sodium chloride which is a *preservative of meat*. Nitric acid will likewise burn off warts, and the same is true of potash which is used for killing the "bud" of the horn on calves. Combined in proper proportions, they form nitrate of potash or saltpeter, used with common salt by our farmers in forming the "pickle" for their barrels of salt pork and, like the salt, it is also a *meat preservative*. Gastric hyperacidity is a precursor of gastric ulcer for which we use the alkaline Sippy powders, and the like, for relief and cure. It is therefore not unreasonable to suppose that bicarbonate of soda, or milk of magnesia, by neutralizing the various acids formed in the stomach, has on the whole a beneficent rather than a deleterious effect. If cholelithiasis is the cause of the sour stomach, it will not be likely to remedy the underlying condition, of course.

One of the greatest advances made in recent years in the treatment of cholelithiasis has been in the way of better diagnostic facilities. Intravenous injections of various kinds along with other measures have enabled roentgenography to throw new light — or new shadows — on the gallbladder and its ducts. Through such pictures thrown upon the screen, the effect of olive oil and measures of this general nature could be tested out. We all see numerous cases where, for various reasons, gallstone operations are hazardous to a degree. If there is any virtue in these non-surgical methods of treatment it should be proven (or disproven), for the class

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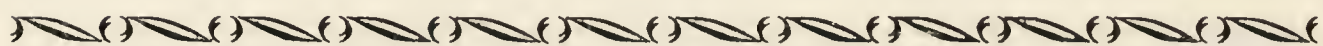
of cases to which I refer needs all the relief available. Here lies an opportunity for the scientific investigator, a field where the sod remains almost unbroken.

Cases of cholelithiasis or gallstones and of cholecystitis or gallbladder infection, should be put on a suitable diet and in most instances this applies to those who have been operated upon also, since in many cases the surgeon removes the effect rather than the primary cause. Undue concentration of bile, for instance, may persist after operation. We make maple syrup in our section. If it is boiled down to an undue extent, crystals are deposited on standing. If not sufficiently concentrated, fermentation is prone to occur. Fats of animal origin, fat meat, butter, cream, and lard are to be used sparingly, if at all. Fats of vegetable origin do not seem to have the same evil effect and for this reason olive and cotton-seed oil and certain of the butter and lard substitutes made from vegetable fats appear to be less injurious. It is best, however, to let the attending surgeon or internist prescribe an appropriate diet for the individual case. In this way recurrences may be avoided.



LIV

HICCOUGH



IN A series of notes made during many years in my Index Rerum, I find under the head of hiccough many infallible cures. These were gleaned from time to time from various medical journals or from my confrères in consultation but space forbids my giving a full list. Until I tried them, they were infallible, but immediately I did, the jinx gat him the bulge on me. These notes show innumerable cases cured with calomel, emetics, inhalations of chloroform, snuff; soot tea, cerium oxalate, hot water; creosote, cinnamon tea. Hot infusions of capsicum, etc., saved many desperate cases; vinegar and sugar, aromatic sulphuric acid or the juice of lemons were infallible specifics. Hypodermics of nitroglycerine, of atropine, physostigmine or pilocarpine were unerring and positive cures. A tight bandage around the abdomen, adhesive plaster about the lower ribs, faradization of the diaphragm, depression of the tongue, compression of the phrenic nerve and inflation of the eustachian tube were simply startling in their efficiency. Bismuth and soda worked marvels and changing the brand of "white mule" in use was efficient in many cases otherwise intractable.

But the best of all, the real crackerjack to stop the hickerjacks was this: "Place a thumb in each ear, the middle finger on either nostril, close tightly, blow out all the breath, take nine swallows of cold water (while holding the tumbler between the feet), take a deep breath and then remove the fingers." It does not say to amputate the fingers, merely to remove them, presumably any old way. This is strangely reminiscent of the couplet about paring your corn in the dew of the morn with a razor that shaved the dead, a time-tried

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and indisputable cure in high repute. With this array to guide one, the cure of hiccough should be dead easy. This may not be a dignified way of putting it, but it must be a fearful nuisance to be always dignified. This is merely my personal opinion, never having tried such an attitude systematically.

I was once obliged to write a number of letters to a wholesale house in the metropolis in order to correct a series of seemingly inexcusable errors on their part. Instead of finding fault, I good-naturedly kidded them, whereat they took offense. I wrote them that I was sorry that they had taken my remarks in a way which I had not intended; I humbly apologized, told them that this time I would earnestly endeavor to suit my mood to theirs and be perfectly serious, that they could go to —— Paradise, and stay there. To be perfectly serious, if any of the foregoing cures were of much value, we would not need them all. We hear of people dying of hiccough which could not be controlled. I question if anyone ever died of hiccough. It is a symptom, not a disease, and no one dies of a symptom.

It is said that hiccough is an intermittent spasm of the diaphragm due to irritation of the phrenic nerve, which is all right in a way but where do we go from here? I am unable to drink ginger tea or ginger ale because I hiccough so rapidly and persistently that I cannot get a swallow in between. It is certain that the ginger never reaches my stomach, my diaphragm or my phrenic nerve, provided that they are located in the customary way. In such a case, it would seem to be a mere reflex, related in form but not in substance to the hiccough that attends the late stages of intestinal obstruction. When one dies of hiccough, it is more logical to suppose that he died of some underlying disease or accident and our treatment should be directed toward ascertaining the nature of this hidden source of trouble and removing the cause, if this lies within our power.

In a general way, I can say that the only treatment which

has given me satisfactory results was not directed to the treatment of the hiccough *per se* but to clearing the intestinal tract. Gastric lavage, followed by thorough purgation with calomel and about two ounces of castor oil, has relieved many exceedingly obstinate cases. I hope none of my readers will consider that I am recommending this line of treatment in hiccough occurring in connection with gangrene of the bowels, in strangulated hernia or in the hiccough which occasionally comes on with uraemia in the late stage of chronic nephritis. The point which I am trying to make is that the underlying factor should be removed, if possible, and in many cases intestinal stasis and a consequent auto-toxaemia is the cause. In such cases the treatment suggested is applicable. In the meantime, some of the symptom medicines may afford temporary relief and even this may be extremely desirable. Somebody told Billy Sunday that the conversions he made were only temporary. "So is a bath!" was Billy's comeback.

Through its action on the respiratory centers, carbon dioxide is quite useful in affording temporary relief. In country practice this can be accomplished by breathing, for five minutes or so, into an ordinary medium-sized paper bag, such as is used by grocers, the bag being fitted snugly over the nose and mouth. The gradual accumulation of carbon dioxide is usually sufficient to afford relief in a short time.

LV

VOMITING

“The wish to be cured is a part of the cure.”

SENECA

VOMITING is due to any one of a large variety of causes, gastric irritation from various sources, disturbances of the vomiting center, reflexes originating elsewhere or from many factors unnecessary to enumerate here. In the commoner forms, due to gastric irritation, a diet of milk and lime water, or, better still, of milk and fluid magnesia, is one of our most efficient measures. The preparation referred to is the *Liquor Magnesiae Bicarbonatis* of the old British Pharmacopoeia or the *Liq. Magnes. Carbonatis* of the later editions, a clear, colorless, slightly effervescent *solution* of magnesia in carbonated water. Dinneford's is a standard English make of good quality. The strength is ten grains to the fluid ounce. If left uncorked and exposed to the air for any length of time, the carbonic gas escapes, the magnesia is precipitated from solution and then it has all the virtues of stale water.

Many years ago it was an official preparation in the United States Pharmacopoeia but it was dropped for some unexplained reason. The United States Dispensatory says that it has no advantages over the carbonate of magnesia. I take pleasure in directly contradicting this statement. It is in solution, not in a comparatively inert powder. It contains a considerable amount of free carbonic gas which, acting similarly to Vichy water or champagne, has a direct sedative action upon the stomach. Change is not always progress and it was a mistake to drop this useful agent from the official list. Milk of magnesia is efficient as an antacid, but for many purposes it cannot and does not take the place of fluid magnesia.

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Fluid magnesia has the merit of being quite harmless. It has been stated on excellent authority that the magnesia salts will produce shock symptoms in certain people. It would be a rash man who would say that this may not occur. I can only say that I have used them extensively for many years and can recall no instance of any untoward effect.

In large doses it is mildly laxative owing to its magnesia content. It works very satisfactorily in the commoner types of vomiting, whether due to indigestion, to acidosis or to pregnancy; it even checks the kind of vomiting described by the Celtic lady who was born on St. Patrick's day (and looked it). One morning I was called and she said, "Oh, Doctor, I vomited the whole night long and could get up nothing at all, at all, but a little string of tough water," spreading her two forefingers vertically, to illustrate. I think we have all seen that particular type of vomiting.

An efficient agent in the vomiting of acute gastritis is iodized phenol. This is made extemporaneously by mixing equal parts of liquid carbolic acid and tincture of iodine. A teaspoonful of the reddish compound so formed is put in a glass of water and it rapidly becomes decolorized. When this chemical reaction is complete, a teaspoonful may be given every hour or so in a little peppermint water or other suitable vehicle, without fear. I have never observed any smoky or greenish discoloration of the urine from its use in such dosage and I have used it habitually in treating these cases. It acts as an antiseptic and healing agent, aside from its use in controlling vomiting. It should not be taken by the patient unless endorsed by the physician in attendance. Most of the anti-nauseants recommended in standard textbooks have proved rather unreliable in my hands, possibly because I did not understand just what classes of cases they were adapted for or in which they were indicated. Bismuth subnitrate is of value in many instances and, in some conditions, which for want of a better name we call biliousness, a round dose of calomel or, if preferred, fractional doses followed by

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a purgative, is all the treatment required. I have repeatedly seen cases of extremely severe post-operative or post-anaesthetic vomiting, which proved resistant to the usual remedies, yield promptly to liberal doses of fluid magnesia.

In the vomiting of pregnancy, the use of the bromides together with plenty of fluid magnesia, has proved invaluable. At one time, during the World War, bromides were almost unobtainable at any price. I had several pounds of it in stock at this particular juncture and I guarded it jealously, feeling that the lack of it might readily cause loss of life to some pregnant woman. In these cases, the bromide and the fluid magnesia should not be given in the same mixture, not that they are incompatible but because it is inadvisable. The bromide should be given in such dosage as will keep the patient definitely on the verge of bromism and this requires fairly close observation and regulation. On the other hand, the fluid magnesia should be given *ad lib.*, as occasion may require, and this freely and without stint.

Once the patient is well under the influence of the bromide of potassium or sodium and the acidity of the stomach is corrected, it only remains to maintain that desirable state. To accomplish the first will occasionally be quite difficult, since many of these cases vomit the bromide as fast as you can put it down. The worst cases are those poor, martyred women who do not want babies and who do everything possible for a perverse woman to think of, in order to defeat our best efforts. Even when the patient co-operates to the fullest extent, it is often difficult to have the first few doses retained. It is essential to make the patient understand that a dose vomited is not a dose taken, in our acceptation of the term, and that it must be repeated every five minutes until it is retained.

In obstinate cases, it is sometimes necessary that the physician himself should stay with the patient and see that she takes it properly and in sufficient dilution to avoid gastric irritation, also to furnish a measure of moral support in re-

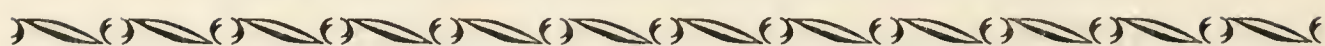
sisting the tendency to vomit the medicine. It may be given in divided doses at intervals of ten minutes until not less than sixty grains of the bromide salt has been retained for a sufficient time to insure its absorption, after which a daily dosage of from forty to forty-five grains is usually sufficient to maintain a proper effect. A few times it has been necessary to give a preliminary dose of morphine and hyoscine or scopolamine hypodermically; when this takes full effect, the bromide can be given by the mouth in full dosage and retained without trouble.

I am fully satisfied that in the majority of cases of hyperemesis, the nervous element predominates, rather than the toxaemic condition. This seems to me fully proven by the uniformly good effect of the bromides, the chief action of these bromide salts being to inhibit reflex action. While toxaemia is much stressed at the present time and its fairly frequent occurrence is freely admitted, in my experience the reflex cases have been in a decided majority. I have had, like most family physicians in the rural districts, an extensive obstetric practice and I think I have had my full share of hyperemesis gravidarum. So far, I have never lost a case from this cause and I have never been compelled to induce labor in such a case in order to control vomiting. With a full realization that I may be open to criticism for making a rash statement, I nevertheless maintain that 95 percent of these cases will yield to this treatment, the remaining 5 percent being, in my judgment, a liberal allowance for a class of cases which, so far, I have not yet encountered.

Additional evidence of the nervous element in a large proportion of these cases is furnished by the efficiency of this line of treatment in controlling many other nervous phenomena so commonly found in the early months of pregnancy. I think, for instance, that when any young woman tells us she is having "weak spells," faint attacks and kindred symptoms, we customarily show a little of the wisdom of the serpent by inquiring as to the date of the last menstrual

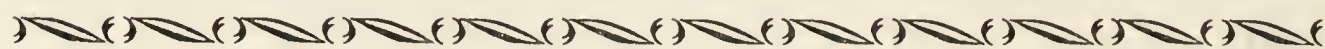
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period. In this connection it is to be recalled that vomiting, when due to toxaemic states, is usually a late symptom, while that due to disturbed reflexes and of non-toxic origin is prone to appear in the early months of pregnancy rather than when nearing term. Vomiting in the later months should always be regarded with suspicion of some serious dysfunction.



LVI

DIARRHOEA



IN RECENT years, the incidence of diarrhoeal disorders has greatly lessened. Thirty-five years ago, I used to tell the public that one housefly swimming in a pan of milk was quite capable of laying out a houseful of children with "summer diarrhoea." I was laughed at by many, but that is quite immaterial. Today cholera infantum, which formerly accounted for a heavy infant mortality in the summer and fall, is comparatively rare. I have not seen a case of cholera morbus in the algid stage for many years. The closer supervision of dairy products by our sanitary officials, the educational campaigns waged against contamination of our food products, the more universal use of screens, the pasteurization of infant foods, the proper sterilization of utensils, all these and other measures I might mention, have had a marked influence in the control of these disorders.

The automobile, the truck, tractor and stationary engine, have to a great extent displaced the horse. The common housefly is infinitely less common, being unable to hatch her eggs with the facility and precision attained in the good old days before her favorite incubator, the omnipresent pile of horse manure, was replaced by a pool of worn-out cylinder oil on a concrete or asphalt pavement. Not long ago, one of our periodicals, the *Literary Digest*, I think, quoted a statement from an eminent scientist to the effect that a single adult housefly in the course of a summer season would have progeny of some 20,000,000. Then the editor wondered how many she would have if she were married.

Another reason for the decreased mortality is the lessened vogue for astringent medicines. It would not be quite accu-

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rate to call them remedies. Rhatany, catechu, logwood, and the like, are now seldom used in controlling these fluxes. More rational therapy by thorough emptying of the intestinal tract, lavage, abstention from food, administration of plenty of liquids, sterilization of food when feeding is resumed, and general measures based on sounder logic, have greatly reduced the mortality in the cases which still occur. For clearing the intestinal tube in this class of cases, nothing is so satisfactory as a full dose of castor oil. It does its work thoroughly, is non-irritant, and its secondary action is decidedly constipating. The objectionable taste of castor oil has been to a large extent overcome, and a variety of comparatively palatable preparations is now readily obtainable. It is commonly given in insufficient dose to secure its fully beneficent action. For an infant, a dessertspoonful is none too much. Any surplus will come away with the last stool, and a good rule of thumb is to be satisfied that you have given a sufficiency only when it is visible in quantity on the dejecta.

It is often objected that frequently it cannot be retained on the stomach. This is seldom true. Gastro-intestinal derangements are commonly accompanied by vomiting and it is no unusual thing for the initial dose to be promptly rejected. The remedy is to repeat the dose every five minutes or so until it is retained, meanwhile allowing no food or liquid of any sort. When the stomach is really empty, it will stay down. One can wring a lot of water out of a bath towel which has been dipped in the tub, but put a tablespoonful of water in a dry towel and try to wring it out.

Castor oil is objectionable to the taste. So is Epsom salt, yet these have been used by the profession for a very long time. They are both popular household remedies. Things don't just happen; there is usually a good reason for them can we but find it. Despite their nauseous and disagreeable taste, they hold their own year after year, with more palatable purgatives, regardless of millions spent in advertising pink purgative pellets and cathartics that children cry for, as con-

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stantly proclaimed. The reason is that neither salts nor castor oil is poisonous or irritating in any conceivable dose.

For a long time, I have used the following prescription in a large variety of diarrhoeal disorders, and it has become an established household remedy in our section. It is used after a preliminary dose of castor oil.

| | | |
|------------------------|------------------|---------------------------------|
| Ol. Ricini | oz. i | For infants, a teaspoonful; for |
| Phenol | m. xii | adults, a tablespoonful, every |
| Tr. Opii Camph. | oz. i | two hours, more or less as may |
| Syr. Acaciae | q. s. ad. oz. iv | be indicated by the urgency of |
| Mix. Shake the bottle. | | the case. |

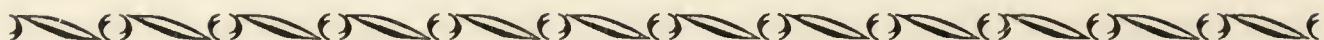
With the small dose of phenol which this mixture contains, I have seldom seen it vomited. I have never seen the slightest indication in the urine of phenol absorption, so that I have long since ceased to look for it. In not one case in a hundred have I had to resort to any additional medication in the ordinary run of diarrhoeal diseases. Naturally, I am not speaking of amoebic dysentery nor the diarrhoea which frequently attends intestinal cancer. I recently had a case of chronic diarrhoea which yielded only to mercury with potassium iodide, but that is another story, and one with a luetic history, or should I say a luetic introduction.

I find that many mothers are apt to give their children castor oil, or other disagreeable remedies, in milk. I am free to admit that milk will cover the taste and make an agreeable vehicle for some of these things, but when we roll the matter over in our minds and look at the underside of it, we will put a ban on giving castor oil or any other disagreeable medicine in milk. If taken in hot coffee, peppermint tea, lager beer and our patients thereby acquire a distaste for coffee, peppermint or lager, no serious harm results. If, however, they acquire an antipathy for milk, if it becomes repugnant to them, it is a far more serious matter, since it may

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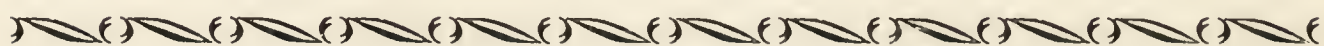
happen that milk will, in the long run, prove of far greater necessity to them than castor oil.

The Lord only knows how many lives have been saved by the exercise of ordinary common sense. Fred Deyette lived six miles away on a road where there was no telephone. The roads were drifted. His baby ate a lot of paris green. The father was hurriedly hitching up a horse to drive down after me. A young girl living in the same house headed him off, emptied the baby's stomach, washed the mouth thoroughly, bundled him up warmly and sent him *with* his parents to my office. The *time* she saved was the chief factor in the baby's recovery.



LVII

CONSTIPATION



I HAVE long been accustomed to refer to constipation as the Great American Sin. For aught I know, it may be the great European or Australian sin but let us not wander too far afield. Among well-recognized causes are the abuse of laxatives and cathartics and neglect of regular habits of defecation. A sedentary life, prolonged confinement in bed, faulty diet, nervous influences, gastro-enteric atony, are other causes. There are a host of factors, functional and organic. Constipation due to organic or mechanical causes, tumors, strictures, etc., will not be here discussed. I recently parted with fifteen bucks for a nice volume by someone on the faculty of Johns Hopkins, in which the writer lists but 183 causes of constipation. Having made a few clerical errors in my time, I am inclined to forgive him if he, with a pardonable human fallibility, has overlooked two or three.

Being neither a scientist, the editor-in-chief of an encyclopedia or the proprietor of a junk-yard, but just an ordinary country doctor, my idea is this: If I went back to my office to read up on the 183 varieties and took proper time to decide between division of the sphincter, ablation of hypertrophied rectal valves, subcutaneous tenotomy of the levator muscles or simple trust in divine healing, I would return to my patient in time to find that the house was closed and she had gone by airplane to the next World Exposition, wherever that may be held.

To understand the cause of constipation, I think we will be compelled to go back a long period of years. A century ago, before the advent of camphene, burning fluid, kerosene, gas, acetylene and electricity, household illumination was

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meagrely furnished by the open fireplace and the tallow dip. Then, the only really satisfactory lighting system was the old reliable solar system. In consequence of this, the majority of people rose early, breakfasted at six, dined at twelve, supped at six and went to bed, if not literally with the chickens, at least shortly after, with subsequent "dreams o' heaven and homemade bread," like Riley's Old John Henry. With a six-hour interval between the meals, there was ample time for proper digestion. Contrast this with the way we live today. The average citizen, so far as it is possible to average such, (bridge fiends and night club prowlers not included) has shoved his bedtime hour from 7 P. M. around to 11 P. M., or thereabouts. He wakes late in the morning, dresses hurriedly, gulps down a rapid-fire breakfast of some cereal which can be washed down with little mastication, grabs his hat and rushes off to his work or to catch the Commuter's Express. Even the children are going to be "late for school" and are likewise hustled off.

A disproportionately large percentage of our women are given to constipation, in many cases more sinned against than sinning, for the average housewife has an extremely limited amount of leisure in the morning hours. There is breakfast to prepare, the children to be awakened, dressed, fed, gotten off to school, the wage-earners off to their work on time, the dishes to be washed, the beds to be made, and it is washing day, baking day, ironing day, any old day, but all days full to the brim with urgent duties. She may have servants to do much of this, but servants who will do all these things without close superintendence are rare as white blackbirds. She feels an inclination to answer the call of nature at what is commonly a natural time, for the reason that the bowels are most apt to move when food is taken following the longest fast, which means after breakfast. But this is her very busiest time; she simply hasn't the time just then and opportunity ceases to knock. Dinner-time comes about noon, but the bedtime hour was late,

breakfast was late; food insufficiently masticated has had insufficient time to digest, and the second meal of the day enters a stomach still containing remnants of the preceding meal, in itself a potent cause of fermentation and all sorts of digestive disturbances.

Two or three days of this sort of sin of omission, and the patient realizes that this must not continue. What is easier then, than to resort to one of the million and one "remedies" for constipation, "nature cures" in tablet, pill or liquid form, each and all of which should be accompanied by an ironclad guarantee that they will serve to rivet securely the vicious habit on the unfortunate purchaser. Unmindful of the fact that after a cathartic, it takes several days for the intestinal tract to fill again so that a natural movement is once more in order, the victim, this time largely through ignorance or misled by the directions on the package, deems it again needful to take another dose and the rivet is properly headed. One so-called remedy after another is tried, is worn out, discarded for something else again. The changes are rung from roughage, pronounced with unintentional humor by one of my patients "rubbish," to other tablets and pills, cascara, mineral oils, enemas, suppositories, colonic irrigations, treatments furtive and squirtive, abdominal massage, adown an interminable list, faradization and what not, particularly the latter, for what *not* to give, in constipation proper, is a laxative or cathartic. Please don't misunderstand me here. These remedies have their uses and their proper place but not in the treatment of what we are getting at.

The remedy lies in an entire change in the mode of living. In going to bed at a seasonable and reasonable hour, in getting up early enough so that there is time *to go to stool when the proper time arrives, in correcting the vicious habit of deferring evacuation* of the bowels to a more convenient time, in correcting dietetic errors. Fresh air, exercise to tone up flabby muscles, to promote muscular activity, are of unquestioned value. It is to be held in mind that only a small proportion

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of all muscular action is that of the voluntary muscles, the involuntary working almost, if not quite, ceaselessly in health.

The patient must be made to realize that the cure of constipation is like salvation; it must come from within rather than without, wherefore I have dubbed it the Great American Sin. She must be made to understand that as one naturally gets hungry at dinnertime, sleepy at bedtime, wakeful at a certain time in the morning, so too the bowels should become habituated to moving at a certain time after breakfast. It should be impressed upon the patient that she should go to the toilet at exactly the same time every day; that if the habit be of long standing she must not look for immediate results; that if she walks in a given direction for five weeks, she may not reasonably expect to reach her point of departure by reversing her course for five hours. *This is the only real cure.* She should be given to understand that while failure of the urinary organs to act freely will be quickly disastrous, a similar lapse on the part of the bowels is of infinitely lesser moment; that most of the constipation cures are effective in much the same way as that adopted by the man who burned down his barn to destroy the rats.

For definite purposes in some surgical cases, I have not infrequently locked up the bowels for periods ranging from two to three weeks, without any special inconvenience to the patient or any untoward effects. Irving A. Frisch of New York has shown quite conclusively that constipation in itself does not produce harmful effects. One woman, who has for many years earned a satisfactory living for her family by doing rough household work, has a bowel movement about once in two weeks, yet is seemingly in excellent health. I am merely stating these facts, not recommending the practice.

For those patients who cannot or will not carry out proper general measures of treatment, resort must be had to other methods. One of these is the use of the coarser vegetables

containing large amounts of cellulose. Their action is explained on the ground that it requires bulky foods to stimulate the bowels and, as an example, it is pointed out that carnivorous animals whose foods lack bulk, have hard stools, while herbivorous have loose stools. Like most things relative to the practice of medicine, this statement cannot be accepted without qualification. While it is true that the bowel movements of our domestic cattle are usually loose, it does not hold true of the horse. The cow feeds on grass or silage while the horse is given dry oats, grains, hay or straw. If the horse is at pasture and eating green foods, he has loose stools. Roughage containing much insoluble cellulose, is useful; such things as oatmeal, graham or entire wheat bread, bran and "doll stuffing" in general. *Green* foods, fresh vegetables, oranges, bananas, figs, prunes and fruits in general, are indicated. One of my patients has no trouble so long as she eats a raw onion at bedtime. Yeast cakes are beneficial with very many people.

Where there is pelvic congestion with cold feet, belladonna is indicated. A half-pint of hot water, early in the morning, is efficient in many cases. Sometimes a pint is necessary. The addition of ordinary table salt or a teaspoonful of the orthophosphate of soda, in crystalline form, will enhance the action of the water materially. Since both these agents are normal constituents of the human body, they are harmless. They are inexpensive and patients do not apparently become habituated to their use as with many other laxatives. Sweet milk is constipating with some people. Buttermilk made with or without the tablets is equally nutritious and not constipating. The sole objection to these aids is that they afford little revenue for the purveyor of constipation cures, but I have little sympathy to waste on these tradesmen.

To discuss the merits and particularly the demerits of the varied and multitudinous laxative and cathartic agents, would require a large volume and the reader who feels the need of such information is referred to the U. S. Dispensatory, see general index A to Z, or the advertising columns of almost

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any lay or medical journal. Even here it is advisable to use a modicum of salt as mentioned in a preceding paragraph.

Several times I have had patients who suffered intolerable pain in one or both great toes, unaccompanied by any inflammatory signs or any evidence of gout. In every instance, all of the customary measures failed to give relief and hypodermics of morphine in quarter-grain doses were ineffective. When two ounces of castor oil were given, there was prompt relief from the agonizing pain. I am at a loss to explain the cause of this pain. They were all stout subjects and it is possible that there may have been fecal impactions pressing on some of the pelvic nerves, but I was not able to make this out. If due to constipation, it must have been a little out of the ordinary.

I recently encountered a case of fecal impaction. When, after prolonged efforts we got the colon unloaded, we found that the large mass consisted chiefly of undigested green corn. She had been in bed for some time with pneumonia and on a liquid diet but it transpired that some six weeks before she had lived for a week or so largely on green corn. Viewing the matter from its various angles, neither the nurse nor I was able to decide definitely whether the impaction contained this year's or last year's corn. Science has its limitations.

Si Perkins was in the drugstore the other day and shouted to the clerk who was behind the prescription counter, "I want three boxes of Wright's Indian Vegetable Pills. Them's my *fa-vo-rite* pill." Is it any wonder that so many people are constipated when we are trained to be so from our earliest infancy? If anything is wrong with the baby, if he even smiles in his sleep (a sure indication of colic?) he is dosed with castor oil or that substitute so widely advertised that children cry for, or at any rate, they get it. The older ones get Cascariums, the kind that "work while you sleep," a most inopportune time, if you ask me. The sight of these fond mothers starting innocent babies on the road to constipation is enough to make the angels weep.

All this is commonplace. There is nothing new in it, but, I believe, it is understandable. It was not written for those whose thoughts "are above the flight of common souls." Doubtless Hippocrates, the father of medicine, and even Dr. Imhotep, the grandfather of medicine (last address, Egypt), spake unto their patients after this manner and doubtless with equal success. Hippocrates says, "Purgative medicines agree ill with persons in good health."

The point I am trying to stress is that the cure of constipation in the vast majority of cases lies in the cultivation of *correct habits of evacuation*. It is as unwise and as absurd to take laxatives for it as it would be to take saltpeter or sweet spirits of nitre every day to insure urination.

Like David Harum, I have had my say, and if I have done anything I'm sorry for, I'm willing to be forgiven.

LVIII

ACUTE NEPHRITIS

WHEN I see in the medical journals an advertisement under the caption, "How Would You Like to Save Eighty-five Percent of Your Cases of Acute Nephritis?" my reaction is possibly not what was anticipated by the writer of the copy. Now, if it were chronic nephritis that would be an equine of a wholly different tint, but *why not* save eighty-five percent of the acute cases? Acute nephritis is a common enough malady, a frequent sequel or complication of the various infections, often occurring without any evident exciting cause.

A woman comes to the doctor's office complaining of dysuria. So far as he can determine from her history and symptoms, she may have anything from urethral caruncle to cystitis, but a urinary test discloses that the urine is loaded with albumin and perhaps not a little blood.

Again, he may have cases that are recurrent, and investigation discloses infected tonsils that gave few or no symptoms, yet when these are thoroughly enucleated, there is no further trouble. Many pneumonias terminate fatally because a concomitant nephritis is overlooked, the restlessness, gradually developing into delirium, being attributed solely to the pneumonia. Particularly in grip-pneumonias, it is always in order to make daily examinations of the urine, and this routine practice will go a long way toward lessening the mortality from pneumonia which has been, and still is, far too high.

The treatment of acute nephritis when not too seriously complicated is simple and remarkably successful, but it calls for a definite aim on the part of the physician, strict observance of orders on the part of the nurse and the absolute

obedience of the patient. Given these and not the eighty-five percent referred to above, but ninety-five percent or better, should be saved. The kidneys should be given as complete rest as possible, the patient being put to bed immediately, on a milk diet. Our efforts should all be directed to securing free action of the skin and bowels. Once a day, preferably at night, a vigorous sweat lasting not less than four hours should be induced. Following the sweat, and preferably in the morning, since it is impossible to purge and sweat a patient simultaneously with any degree of success, a vigorous purge should be given, preferably a saline. If the kidneys are seriously congested, either wet or dry cups over the loins are of service. The urine should be measured and examined repeatedly as an index of progress.

Some authorities advise against the giving of milk or much fluids on the ground that it throws too much labor on the kidneys and favors anasarca. If the patient is treated after the manner outlined, no fear need be felt on this score and large amounts of fluid are essential in order to replace that lost from the tissues through perspiration and the profuse watery evacuations. No fear need be felt that the sweating will weaken the patient so long as he be plentifully supplied with fluids. On the other hand, retention of poisonous products through defective kidney action, when the eliminative action of the skin and bowels is not substituted to bridge the gap, is not only weakening, but if not quickly fatal, will prove finally disastrous, leading to permanent impairment of the kidneys. I recall with profound regret the case of a strong, robust bull-moose of a man whom I saw in consultation. My advice to sweat and purge him was turned down on the ground that he was too weak to stand it. The toxins in his system proved within thirty-six hours that he was indeed weak to the final and deplorable limit. The law of diminishing returns, as regards urinary output, got in its work.

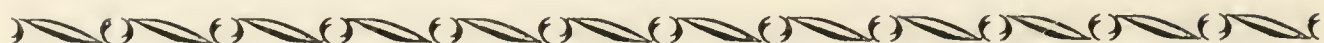
In these cases medication comes last, if not quite least. I have, however, had much satisfaction from a modification

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of Basham's mixture. Free diaphoresis may be obtained by a full dose of quinine and Dover's powder with a hot lemonade. Hot packs or hot wet bricks as directed under pneumonia. Aconite is a useful adjuvant. Above all, let your weapons be steel-blue and blade-straight and send them home. Purge them and sweat them fearlessly. Most of our authorities agree that this is the proper way to treat an acute nephritis but, in practice, I find that it is generally carried out in a half-hearted and haphazard manner. . . . Doctors make troublesome and rebellious patients. They are accustomed to give orders, not to take them. When you tell them what they must do, you are rubbing the fur the wrong way. . . .

If my memory is correct some years ago a mock trial was held by some prominent people in England. During the course of the trial, the presiding magistrate took occasion to rebuke the jury sharply for inattention to the evidence which was being presented. George Bernard Shaw was the foreman of the jury and he rose and protested to His Honor, the judge, that it was manifestly unfair and unjust to expect that *any* amount of evidence should influence the convictions of any honest British juror.

If my readers are convinced that most cases of acute nephritis are unable to stand the depleting effects of sweating and purging, it is wholly useless for me to argue the matter further. Much that I have written is trite and has been said before but the same criticism would apply to Matthew, Mark, Luke and John.



LIX

CYSTITIS

“Mice, rats and such small deer.”



IN COUNTRY practice, it is frequently an impossibility to treat cystitis by bladder irrigations, this because many cases are so far removed from the physician's office that they are unable to come with any regularity, and it is equally difficult for him to visit the patient. Many of the cases do perfectly well without local treatment of any kind. Formin is of much service and hexylresorinol is a valuable remedy. I have had on the whole more uniform success in the ordinary run of cases with a mixture of one part of oil of sandalwood and three parts of balsam copaiba than with any other agent. I give this before each meal, one capsule either No. 0 or No. 00 size being filled with this as required. There is a mild form of cystitis, occurring chiefly in women, which is very promptly relieved by a tablet of methylene blue and kavakava comp. This is a standard tablet put up by most of the manufacturing pharmacists and it seems to be always potent. Dysuria in women is so frequently due to an acute nephritis that a urinalysis is always indicated. If this is not found, a local examination is in order, since urethral caruncle is quite common, and the only effective treatment is complete removal. In many of these cases, the electrocautery is a convenient method of destroying the vascular growth.

It must be remembered that stricture is not confined to the adult male. I did an internal urethrotomy within a short time on three boys, all of them under ten years of age, and all first cousins. The trouble was not due to obstruction in the posterior urethral valves. In all three, the evidence seemed to indicate that the trouble was congenital. Women, and

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not necessarily multipara by any means, quite commonly complain of leakage of a few drops of urine under the impulse of jarring, as from coughing, sneezing, a sudden misstep, etc. They are grateful when this annoying condition is relieved by a tablet of $1/100$ grain of atropine twice a day or a mixture of the tinctures of belladonna, nux vomica and cantharides.

Nocturnal enuresis is frequently very troublesome to cure until the age of puberty. Ergot, strychnia, belladonna and a host of remedies have been advocated, together with careful training. In many cases that do not respond to these standard remedies, thyroid extract deserves trial and fluid ext. of *rhus aromatica* has been beneficial in my hands. I have had the best results, however, with potassium iodide. The addition of potassium bromide is advisable in many cases to allay vesical irritability. How the iodide acts I am unable to explain. A number of cases taking the iodide for other reasons, reported a marked improvement in vesical control, and after testing it out, I have relied, of late years, more on this remedy than on any other. I give it in moderate doses continuously for several months. In some cases the syrup of the iodide of iron is preferable. Flavoring with soluble fld. ext. of ginger makes it more palatable. I have seen not a few patients, with cystitis of an obstinate nature, cured by mercury and potassium iodide. The inference is, of course, obvious, though most of these cases showed no evidence of syphilis.

Hemorrhage from the bladder or kidneys frequently yields to formin, the tablets of methylene blue compound above referred to, or to oil of *erigeron Canadensis*. It is, naturally, much wiser to have a proper examination, microscopic, cystoscopic or roentgen, of the urine and urinary tract but where this is not available, the remedies referred to are of distinct service. Some years ago I had a patient that died suddenly from an uncontrollable hemorrhage from the bladder. An autopsy disclosed a large dermoid cyst of the

ovary (containing a long lock of hair) which had caused large varicose veins in the bladder from pressure. One of these had burst and she was soon exsanguinated.

In catheterization, there are a few procedures not always mentioned in the textbooks, some of which have helped me out when I was a long distance from my office and without my usual array of assorted sizes and types of catheters, filiform bougies, tunneled sounds and all the paraphernalia required for difficult cases. In using a metal catheter in males, an excellent rule to follow is that of Gouley's, always to try a large instrument first. A finger in the rectum and the thumb on the perineum can guide and direct the tip of the instrument accurately. If the prostatic curve of the instrument is such that it hitches at the prostate, a little gentle pressure an inch in front of the anus will often overcome the trouble. At other times, when obstruction was encountered, by using a syringe attached to the catheter and injecting warm sterile water, I have been enabled by rotating the point of the catheter slightly, to gain entrance. I have frequently been called at night to relieve some case of retention. I have saved myself many an uncomfortable and weary trip by telling them to try a large injection of warm water in the bowel, retaining it a few minutes and then passing the urine with the enema. Such unnecessary night calls are to be avoided in this North Country where, as Nina Wilcox Putnam says, we are prone to have very unseasonable weather for this season of the year as is commonly the case, if you understand what I mean.

One man said that the darkest thing he ever saw was a nigger, on a dark night, in a cellar, hunting for a black cat that wasn't there, with a lantern that had just gone out. On a similar night many years ago, I was called about 1 A. M. to a confinement case in a neighboring village. In those days we rode saddle horses or used buggies. I heard a horse and buggy coming down the road to meet me and I turned out as far as I deemed safe. I first thought, from the speed with

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which he was coming that he was either drunk or after a doctor. From the quiet way in which he was urging his horse, I decided it was the latter. As he approached, I called to him, "Look out! There is a rig here. Don't run into me."

He reined in his horse sharply and inquired, "Who is it?"

I object to being called an "it" so I answered (somewhat curtly, I fear), "The doctor."

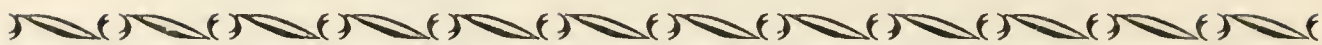
"Which doctor?"

"The homely one," I answered.

"*You're the very one I'm after,*" he blurted.

I had a busy night shuttling back and forth between two confinements about one-half mile and about two hours apart. Moral. At times even an Apollo may be handicapped.

This reminds me that I was many years ago called to a pneumonia case eight miles away in the whippoorwill country, rather a desolate region. It was in the spring when the clay flats were impassable even in those horse and buggy days, so I merely took my saddlebags and went horseback. The diagnosis of the husband was seemingly a little at fault for the only thing I could find was that his wife was having twins. The chief thing I had in those saddlebags which proved of use was a small bottle of lysol, with which we got along very nicely, thank you.

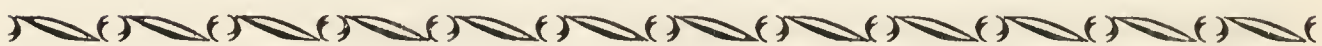


LX

RHEUMATISM

“Wit consists in knowing the resemblance of things which differ, and the difference of things which are alike.”

MADAME DE STAEL



As A free, independent and somewhat controversial American citizen, I am entitled to my opinion so long as I do not make an unmitigated nuisance of myself. Rheumatism, to my mind, is not a disease but a loose term applied to a large group of conditions accompanied by pain, lameness, soreness, stiffness, swelling, and arthritic or other involvement but due to a variety of etiological factors in many instances wholly unrelated to each other. Bronco Pete said, “I don’t hold with this idear that manual labor is degradin’, nohow. It’s wus-ern’ that. It’s disgustin’,” which somehow expresses my attitude toward rheumatism, it being even worse than a disease in that it points to some underlying condition which we not only fail to understand but often have not even suspected, trichinosis, for instance, or undulant fever. *Focal infections*, of course, but even these will not cover all the cases which we encounter.

Many cases follow directly from exposure to cold and dampness without intervening symptoms. There is no question raised here as to the brilliant results frequently obtained by the removal of tonsils and adenoids, by draining of sinuses, by removal of infected teeth and diseased gallbladders, in fact, I’ve had quite a few myself, yet we all have seen some of these unfortunate people who have gone the rounds, have had all sorts of possible foci removed and still suffer. Much remains to be learned about these conditions classed as rheumatism and there are many different types, the origin of

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which is problematical. A water-jacket and a rain-coat are separate and distinct things. There are essential differences between a parrot, a pirate, a pilot and Pontius Pilate. One must learn to distinguish between the different forms of "rheumatism" which have only a superficial resemblance.

One of the most serious diagnostic errors, a mistake which is far too common, a blunder which, if not promptly corrected, leads to death or, at best, to serious crippling, is osteomyelitis when not recognized. This is an infection of the marrow or of the cancellous tissue of the bone. In my consultation practice I not infrequently find that the high fever and intense localized pain is diagnosed as rheumatism and treated accordingly with disastrous results. The attending physician fails to realize that he is flirting with death. The son of one of our former Presidents died of this trouble. In this instance there was no lack of skilled doctors in attendance but, as I viewed the matter at long range from the start, it seemed to me that it was a case of too many cooks spoiling the broth.

The salicylates and their various derivatives are, of course, invaluable in many cases of rheumatism but who of us can say, with any degree of assurance or without a more or less empirical trial that, in a given instance, they will be of any avail. The treatment which is successful in one case fails utterly in another, and this is to be anticipated when "rheumatism" may be due to anything from lithaemic states to Neisserian infection.

We will never meet with much success in treating rheumatism as a disease. When we get down to brass tacks and treat the underlying causative factor (having first learned to recognize it), we will have far better results. Meanwhile, elimination by sweating, by dry heat, the alkalis and many other things, affords relief at times. The salicylates are quite capable of producing a gastritis if given in concentrated form, as in tablets. They should be given in dilute solution with an alkali to avoid liberation of free salicylic acid. In overdose

they are capable of causing depression and delirium but I have never seen any real damage from their use. In full dosage, the salicylates will make the ears ring and produce temporary deafness.

In giving the salicylates, one thing should be borne in mind, if once this roaring or ringing sound is well manifested without any amelioration of the patient's condition within the following forty-eight hours, it might as well be discontinued and recourse had to some other line of treatment. The salicylates will either fish or cut bait, put up or shut up.

Now, on the other hand, remedies like potassium iodide act slowly and it is necessary to give such for a prolonged period, gradually increasing the dose if need be; the iodide for instance, unlike the salicylates, having no definite dose limit. When Heberden's nodes, those unsightly knobs on the finger joints, are present, the iodides always seem to furnish relief to a greater or less degree. Where the salicylates fail, and particularly in muscular rheumatism, I have had more uniform success with potassium iodide than with all other remedies put together. It is slow but, used intelligently and perseveringly, it is extremely effective in a large proportion of otherwise obstinate cases. At times some of the ampoules adapted for subcutaneous or intravenous use have been of great service but potassium iodide is so readily absorbed from the stomach, appearing often in the urine within a few minutes, that the necessity for using it by injection seldom occurs.

Potassium bicarbonate has been an efficient remedy in many cases. The use of the mixed vaccines in rheumatism has, in my hands, proved so disappointing that I have discarded them along with most of the mixed vaccines. Some critics may arise here and ask why I discuss the treatment of rheumatism when I stated that there is no such disease. The term is a convenient one. We still speak of dropsy, yet we all know it is no longer considered a disease. We can go

duck-shooting without confining our attention to one particular species.

Acute rheumatic fever, acute articular rheumatism, is perhaps entitled to stand at the head of this ill-assorted class of maladies. Here the salicylic group constitutes our chief reliance. I have used the true salicylates from oil of wintergreen or oil of birch. I have not been able to perceive any better results from them than from standard makes of the synthetic. The taste can be disguised by essence of wintergreen or by the soluble fluid extract of ginger. The officinal fluid extract of ginger precipitates a resinous substance which is unsightly. A little salt on the tongue will disguise the sweetish taste and mitigate the disagreeable aftertaste. As before stated, it should be given well diluted and with an alkali, else the acid gastric juice may liberate salicylic acid, if not already present in the sodium salicylate in a free state. Unless one knows he has corns or warts in his stomach, this contingency is to be avoided. Curiously enough, salicylate of soda, given with an alkali, is sometimes quite effective in quieting a nauseated stomach. In acute rheumatism, the development of pleurisy or pericarditis is fairly frequent. Any difficulty or pain in swallowing should lead to an examination for a possible pericardial effusion.

Between acute rheumatic fever and chronic rheumatism, there are many degrees and types. The more acute the symptoms, the greater the likelihood of getting results from the salicylates. In just the measure that I have learned to differentiate the different types of this group, in just that measure I have been able to combat these conditions with some success. The whole matter is largely in a chaotic state as yet, and it will take years of patient observation and investigation before these conditions will be properly classified and the indications for treatment clearly interpreted.

Gout, in its typical form, is seldom seen in this section, yet we not infrequently have it in a modified form. In gouty joints there is tenderness along the transverse processes of

the joints affected, rather than along the tendons as in most forms of rheumatism. This together with the mode of onset, the enlarged and tortuous veins, the pitting on pressure and the subsequent peeling of skin, are aids in determining the diagnosis and distinguishing it from rheumatism. Colchicum is still one of our best remedies for gout, as well as for certain allied conditions, for instance, when there is excessive formation of uric acid with whitish or brick-colored granular deposits in a high colored and highly acid urine. Colchicum is a remedy to use with a measure of caution, since overdosing may cause acute poisoning with symptoms of gastro-enteritis, such as vomiting, purging, dizziness and syncope. The antidote is opium. I have tried many of the newer synthetic agents for gout and rheumatism but they have seldom lived up to my expectations.

A lady from Brooklyn recently came to my office and told me that she had been a martyr to neuritis for the past twelve years, that she had been treated in various institutions and by various specialists without benefit; that she had had electrical, vibratory, and osteopathic treatments, had been baked, radiated, massaged, all without avail. Being up in this North Country on a visit, she recalled that many years ago I had treated her successfully for a severe rheumatism and said, "The pain of my neuritis is so much like that of the rheumatism from which I then suffered that I thought I would come and see you and ask you if more of that same medicine might relieve this neuritis pain."

I told her that I thought it would. Mentally alert, she caught the twinkle in my better eye and immediately asked, "What is the difference between neuritis and rheumatism, anyhow?"

"In your case, Madam, probably about \$8.00 per office call. You probably pay the Brooklyn doctors \$10.00 and me \$2.00." I gave her a prescription for the same salicylic-iodide mixture I had given her long before and she got prompt relief.

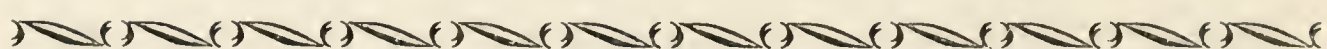
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About one o'clock one summer night I was traveling through the St. Regis Indian Reservation and saw a man with a horse and buggy standing in the middle of the road. He was holding the horse by the bridle and wavering slightly. I stopped my car and inquired what was wrong.

"Drunk as hell. Don't know who in hell I am."

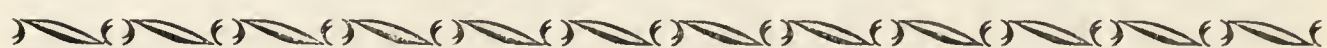
"You're Dominick Curlyhead and if you go ahead about fifteen feet and turn to the left, you'll be in your own yard."

But what I started to tell before I got side-tracked was that old Dominick came into my office one afternoon after some medicine. As he was leaving he looked at me with drunken gravity and, tapping himself on the chest, said, "Me the best doctor. Cure cussumption in two days." I humbly admit that I am very seldom able to cure even rheumatism in that length of time.



LXI

SCIATICA



IN DISCUSSING sciatica, the majority of writers draw fine distinctions between sciatica and sciatic neuritis. There is a distinction between a hard and a soft-shelled crab but it is not one of species. Since the treatment of sciatic neuralgia, sciatic neuritis and peri-neuritis is essentially the same, no such distinctions will be here considered.

Sciatica is attributed to arthritis of near-by joints, to anatomical abnormalities, disease of the lower spine, pelvic conditions causing pressure on the nerve, to strains or exposure to cold, to focal infections, to general conditions such as syphilis, rheumatism, gout and diabetes. Some of these can be dismissed as relatively unimportant. A sciatica due to some congenital anatomical malformation should be constant and its occurrence exceedingly rare. A review of the cases in my card-index shows that exposure to cold and strains constitutes a large majority of the cases which have come under my observation. The recurrent and chronic cases were chiefly due to focal infection while the number assigned to syphilis, gout, diabetes, etc., was very small. Many started as a lumbago, the pain apparently shifting to the sciatic nerve later on. While a difference in degree is an insufficient warrant for a difference in terminology, a difference in location may be, for the sake of clarity if nothing more.

Sciatica is often an obstinate trouble with a marked tendency to relapse. In former years I was accustomed to tell my patients that it usually took five doctors to cure a sciatica, and unless I happened to be the fifth, I was out of luck. In the treatment of this affection, morphine should be avoided as much as possible, for obvious reasons. If some constitu-

tional disease, such as diabetes or syphilis, is present, such conditions are of major importance, but in the main, local treatment is what we find recommended in the textbooks, such measures as rest, fixation, heat in its various forms, diathermy, the roentgen ray, a row of blisters along the nerve, various procedures for nerve-stretching and the application of the cautery. The latter amiable proposals are not greeted with much enthusiasm by the patient unless the sciatica is severe or unduly protracted. Injections of hot saline solutions along the nerve sheath, with other agents added at times, have afforded marked relief in some cases.

I have had a number of severe attacks of sciatica and of lumbago. I had my teeth examined and X-rayed. The results were negative and I was advised that there was no reason for their extraction. Some of these teeth did not feel "comfortable," however — I know of no better way to express it — and I insisted on their removal. The beneficial effect was immediate and I have had no recurrence of the "rheumatic" manifestations for a number of years.

In obstinate cases, I have had the best results (in the way of local treatment) from the Paquelin cautery, applied lightly but freely along the course of the nerve from the spine down to the calf of the leg. In highstrung and sensitive patients an anaesthetic is often necessary but many prefer to follow the advice of the old lady who received so much comfort from that wonderful Bible text, "Grin and bear it." Having used the cautery more than once in my own case, acting in a double capacity as operator and patient, I can assure any patient with a full-fledged sciatica that, like Mark Twain's comment on Wagnerian music, it is really not so bad as it sounds. I have not found it unreasonably hard to bear; it was not half so bad as the sciatic pain.

In one case I had to repeat the cauterization in three weeks before full relief was secured, but this man had been wholly incapacitated for work for two years. Many of these obstinate or recurrent cases have traveled long distances to get me to

use the cautery again, having profited by previous experience. It is reasonable to suppose that they do not again seek this kind of treatment unless they are convinced that it is effective.

Aspirin and similar preparations are of benefit in relieving the pain temporarily. I have found a few cases that were benefited by the salicylates. Potassium iodide is recommended by a number of authorities in the chronic cases. In this I fully agree with them. I can only add that it has been of even greater benefit in the acute cases, and of late years I have used it almost as a routine treatment, in full dosage, with exceedingly satisfactory results.

While on the subject of sciatic neuritis, it may be worthy of note that I have met with an occasional case of zinc neuritis apparently due to the use of galvanized iron piping in the water-supply system. At any rate, removal of this type of piping was followed by relief of the neuritis together with the abdominal pain, nausea and gastro-enteritis. I have seen no reference to this in medical literature but its possibility should be borne in mind. I have likewise found that severe tri-facial neuralgia will often yield to full doses of sodium salicylate and occasionally I find cases that are entirely cured by giving them plenty of quinine. Such remedies deserve a thorough trial before resorting to operative procedures.

About fifty years ago we had a doctor in Fort Covington who had an active practice. I was then in charge of a pharmacy and filled all his prescriptions. He seemed to get along with a very small list of remedies: Boudault's wine of pepsin with hydrochloric acid for nearly all digestive disturbances, J. Collis Brown's chlorodyne for colic, cramps, diarrhoea and painful internal troubles, Epsom salt and cream of tartar for bowel and kidney derangements, carbolated oxide of zinc ointment for all and sundry skin affections and his famous Hell-Fire Liniment for anything and everything. I can say this much for him: he understood how to use his few weapons. A teaspoonful of chlorodyne added to four ounces of simple syrup made a very satisfactory cough syrup in most

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cases. His liniment was a wonder, not so much from its make-up as from the way he applied it. The formula was one ounce of Squibb's chloroform and three ounces of tincture of belladonna. He insisted on Squibb's chloroform as he found that the ordinary chloroform then in use would blister. His method of use was to saturate a piece of heavy woolen cloth (a piece about the size of a silver dollar) with this bottled Hell-Fire, apply it over the seat of pain and cover it closely with the palm of the hand. Between the heat of the patient's skin and the warmth of the hand, the chloroform was confined and took prompt effect. Any of his patients would swear that it was efficient in relieving pain; all of them would swear that the name of the liniment was appropriate and some, not all, were simply content to swear. This liniment, rubbed on or in, was no better than any other liniment, if as good, but patients with sciatica and kindred ailments got much comfort out of it and it had the merit of giving them something to occupy the mind while it was being applied.

Joe Hall came to see me one morning. He had a tumor on his shin bone. I told him if he would stay over until the following morning I would etherize him and remove it. He insisted that I do it then and there. I explained that, while I could use a local anaesthetic on the soft parts, the use of a mallet and chisel on the bone would be exceedingly painful. He could not be dissuaded and from time to time his wife, who was the only other person present, would ask me to let him rest a moment for she knew I was hurting him each time I used the lead mallet.

"Let the doctor alone. He's too busy to listen to your clack," said Joe.

"But he is hurting you, Joe," she kept saying.

"No, he isn't," persisted Joe.

"Joe Hall. I know he is, else why do you make such a face when he hits that chisel?"

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“A fly swatted me in the eye. Can’t a man change his countenance if he wants to?” and to such a man I lift my hat with as much grace as I possess. Were it necessary to use the actual cautery on him I believe he might actually have pleasurable sensations during its application.

LXII

LUMBAGO

THE country is flooded with advertisements of kidney pills, with pictures of someone dolefully bending forward with his hands on his back and an expression of abject misery. Small wonder, therefore, that the laity believes lumbago to be due to kidney trouble, and incidentally that the kidneys are located some eight inches below where they are usually found. No doubt one can have backache in certain forms of kidney disease, but equally without doubt it is exceedingly uncommon. Nor is ignorance of this solely confined to the laity. The chiropractor says it is due to impingement of the spinal nerves by misplaced vertebrae. The makers of certain proprietary remedies for the uric acid diathesis maintain that it is due to excessive acidity and cite numerous cases of lumbago which were entirely relieved in from two to four weeks by means of their special remedies; this, regardless of the fact that in a very large proportion of lumbago cases the urine is neutral or faintly alkaline. A cure of lumbago that requires four weeks is much like a cure of typhoid which takes a corresponding length of time, to be classed in with a bone knitting on the ninth day, with the efficacy of blood beads and hokum in general.

It is more than a simple myalgia, more than a strain of the lumbar muscles. It occurs with greater frequency in men than in women, though this frequency is rather more apparent than real, since many cases of backache in women are incorrectly attributed to retroversion or some uterine reflex. A strong and healthy man will suddenly make some slight awkward or unanticipated movement and will be seized with a "crick" in the back which renders him helpless, although the disability is apparently all out of proportion to the seem-

ingly trivial traumatism. This peculiarity lends a measure of plausibility to the claims of a cult which attributes everything from baldness to beri-beri to subluxations of the spine, regardless of the fact that the vertebrae are held together so strongly that dislocation is commonly associated with fracture. I venture the assertion that when the real etiology of lumbago is worked out, most of the cures now advocated will pass out. It has seemed to me that there are as many causes assigned as there are cures recommended, and that most of them are pure guess-work.

The indications point fairly strongly to poisoning from accumulated toxins, from focal infections, hepatic insufficiency, faulty metabolism, deficient elimination. True, many of these cases come on suddenly, but this is also true of eclamptic seizures which are due to poisonous products in the system. Epilepsy, migraine, various nerve storms are almost explosive in their onset and have some undoubted connection with faulty metabolism. If, after operating under ether in a small, ill-ventilated room, you light a cigarette, and a sudden explosion occurs, it undoubtedly proves that smoking is a bad habit. However, on reflection, one is compelled to admit that certain preceding factors cannot be ignored. Given conditions which are just right, a slight traumatism is capable of producing results which are wholly disproportionate to the injury received. One fairly common cause of an attack of lumbago is sitting in a draft where the back gets the air current, possibly when undressed to the legal limit for males. Chronic lumbago I have not uncommonly found due to faulty position, as in driving a car with an unsuitable driver's seat or, in the old days, too constant use of the "lazy back." The horseback rider, the cavalryman, the cowboy, does not complain of a lame back because he sits upright and uses his spine as nature intended. I have seldom found sacro-iliac disease. Lumbago has been attributed to everything from malaria to flat feet.

Hobos seeking snug hibernating quarters would flock into

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Bellevue during the late fall and many of them had lumbago — or said they had it. Anyone who has ever had this affliction can very easily put up a close counterfeit of lumbago and it is often extremely difficult to detect this type of malingering. In order to separate the sheep from the goats, the bad actors from those who were real sufferers and deserved good treatment, we were accustomed to apply the actual cautery, brushing the surface of the back with a white-hot platinum point by means of the Paquelin cautery. Such treatment is rather startling to the patient but is not really very painful and leaves no scar, the outer layer of the skin being merely glazed by the superficial burn. Those who really had lumbago would submit to the treatment without protest, and were kept under observation for the few days ordinarily required for complete relief. The faker swore by all the saints, good and bad, and fought for freedom (which he got immediately) and we thus saved our crowded wards for those in dire need.

The remedies suggested for this condition are innumerable. Quinine, aspirin, phenacetine, hypodermics of morphia, purgatives, the salicylates, alkalis, buchu, hot applications, massage, sacro-iliac supports, vibratory treatments, strapping the back, various therapeutic lamps, electrical and all sorts of local applications, any and all of which may, at times, give a measure of relief. Cases of lumbago come to me with the diagnosis of lateral curvature of the spine, displaced vertebrae, strain of the spinal ligaments, sacro-iliac disease, rectal, uterine or prostatic trouble. Such pronouncements are not “woven in the fabric of their dreams” but have usually adequate evidence of being present. The question in many cases is this: Are these findings really responsible for the lumbago or backache? Many lumbago cases need careful examination when stripped and, quite frequently, an examination under the X-ray. The vast majority of these cases I find respond to the treatment below described. Sneer at this, if you feel the inclination. It will not disturb my enjoyment, and anyway, as Paley said, “Who can refute a sneer?”

In this section, if not elsewhere, *about ninety percent of these cases are relieved very promptly by iodide of potassium*. I give it in small doses every two hours, in the acute cases, and increase the dose gradually but steadily to the limit of tolerance or, rather, to the point of intolerance. If I happen to know that the patient is not oversensitive to the action of iodine or the iodides, a few larger doses will take effect more promptly. If the urine is excessively acid, a condition I seldom find in lumbago, I use citrate of potassium or the bicarbonate of potassium in addition. I am somewhat at a loss to explain the almost specific action of the iodides in these conditions save that it is a glandular stimulant and eliminative, removing waste products from the system. I only know that, after trying out all the customary methods of treatment, I have for many years settled down to this as a routine treatment from which I rarely have occasion to vary. I seldom resort of late to strapping or any local measures. Many of our best remedies were arrived at by the trial and error method. It is a slow process and, perhaps, utterly unscientific. With sufficient trial, the errors are eventually eliminated.

Occasional cases of lumbago which do not respond to the iodides are relieved by full doses of the salicylates but, on the whole, they have been a source of repeated disappointments with me. Quinine is efficient in a certain number of cases. We have no malaria in this locality. One need not look for benefit from the iodides in cases of backache due to inflamed hemorrhoids or cancer of the prostate, but in the vast majority of true lumbagos or lumbago-like backaches, it is a very reliable agent. Some people have great faith in Haarlem Oil which is recommended for the cure of lumbago. Why should they not have faith when the original circular around the bladder-capped vial has the caption, "Medicamentum Dei Gratia Probatum?" Our modern nostrum-advertising experts are liable to get a lumbago from straining themselves in the effort to go any farther in the way of claims.

Many cases of torticollis and stiff neck, "crick" in the

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neck, are closely analogous to lumbago. Spasmodic torticollis is frequently a very troublesome affection. So far, I have never had to resort to surgical measures save indirectly through removal of some focal trouble. That these conditions are not due to impingement of the nerves seems evident from certain facts. Some of these nerves emerge from a closed canal while others lie occasionally in a shallow groove instead, and in such cases a sudden twist of the neck in some unusual direction may accidentally roll the nerve out of its groove, causing it to become pinched. Such a pinching is, however, attended with the peculiar numb, burning and tingling pain so characteristic of nerve bruising. The pain comes on suddenly, is intense and bears no resemblance to the pain of torticollis or lumbago, passing off in a few minutes though some tingling may remain for a time.

That focal infection is one definite cause of torticollis was conclusively demonstrated to me in 1889 when I was an interne in Bellevue. We had an aggravated case of spasmodic wry-neck which had been in the wards and under various lines of treatment for some months. On the morning when the house surgeon's term had expired and I had succeeded him, while making my rounds, this man said to me, "Well, doctor, you are in charge now. What are you going to do for me? I am getting pretty tired of this." I looked him over, took out about a dozen of old and decayed teeth, all of them showing root infection, and a few days later he left the hospital quite well and remained so.

I have had a number of similar cases, others which were due to infected tonsils, obstinately resisting all treatment until I removed the focus of infection. In one case of torticollis of unusual severity, there was a chronic involvement of the antrum. I did a Caldwell-Luc on him with a prompt recovery from his torticollis. In this connection it may be of interest to mention a case occurring in a "cancer family" in the Province of Quebec. This tendency to malignant disease was so remarkable that I have briefly written it up under the head-

ing of Cancer *q. v.* For the present it is sufficient to say that a number of children in this family have died of cancerous diseases in one form or another. The case in question was an infant who slowly developed a hard mass, almost stony to the touch, in the belly of the left sterno-mastoid. I could definitely rule out a hematoma of the muscle and I could find no evidence, by tests or otherwise, pointing to syphilis in either parent or any of the children. Before subjecting this young child to the formidable operation of complete removal of the muscle and surrounding tissues, I put the baby on potassium iodide and the growth disappeared promptly, like a cake of ice in a July sun.

Most cases of torticollis of the "crick in the neck" type respond to the iodides as in lumbago proper. Massage of the affected muscles with some of the iodine ointments is of much benefit and I would urge that such measures be employed before resorting to surgical procedures. There is little real glory in donning rubber gloves, a white apron and using a sterilized knife until other means are shown to be ineffective.

A number of years ago I had a stout and muscular patient who was confined to bed with a lumbago. He sent for me and told me that he was subject to such attacks and that he was usually disabled by them for three weeks or more; he said that he had some urgent affairs to attend to and hoped I might be able to suggest something which would enable him to get out of bed in a few days. I gave him potassium iodide and the next day he was free from his disability. He had several subsequent attacks which were relieved very promptly by the same treatment. Recently, while on a visit to New England, he had one of his customary attacks. He told me that he was in a hospital for four weeks and that they gave him various treatments, hypodermics, electrical treatments, massage, baking, etc. When I suggested to him that on his next trip it might be wise to carry with him a bottle of his lumbago medicine, he said, "But this was not

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one of those mild attacks. It was a severe one." I changed the subject. He had utterly forgotten what he had told me at my first visit. We get credit often when it is not really deserved and it all comes out in the wash. I had not seen him "at his best."

He reminded me in a way of one Antoine Larouche. A friend met him and said, "Antoine, I was very sorry for you. I see at de funeral how bad you was feel for lose your woman."

Antoine inquired, "Did you see me at de church or at de cemetery?"

"At de church, Antoine. Me, I could not go to de cemetery."

"Mon Dieu! You should 'ave seen me at de cemetery. I jus' raise Hell at de cemetery."

Dr. Robert T. Morris, a surgeon of world-wide fame and a noted author, recently wrote me, "The worst case of spasmodic torticollis that I have ever seen, a school-teacher whose chin was on her ribs, was cured by Dr. Woodward by correcting an error of refraction." I have seen one similar instance in my own practice.

If I am mistaken in my contention that the iodides are the most efficient and dependable of all our remedial agents in lumbago and similar conditions, the numerous repeat orders for "some more of that lumbago medicine" would indicate that a host of others are similarly in error. I can recommend it with the utmost confidence.

To recapitulate—but it may be better to simply capitulate since no less an authority than Miss Lydia Pinkham states that all backaches are due to uterine disorders. Surely this pronouncement should definitely settle the matter for all time.

LXIII

APPENDICITIS

THE road to success in the management of acute appendicitis, as we see it in the more remote rural sections, is a hard and thorny one beset with pitfalls and man-traps. Many of these our city brother fails to duly appreciate, if we are to judge from the rules laid down for our guidance. It is one thing, when one encounters an acute appendix, to call up the superintendent of a near-by hospital to have the operating room prepared for an emergency operation, to slip the patient into an ambulance and, with plenty of skilled assistants and nurses, to remove his appendix. It is something else again to be called to such a case some fifteen miles from your office, and much farther from the nearest hospital, to telephone in vain for an assistant and a nurse, to decide promptly, without benefit of consultation, whether you have a gangrenous appendix, a perforation and localized abscess, or one of those dread cases where nature has failed to throw up any rampart of plastic exudate, and there is a general peritonitis and septic infection.

Here you may have to contend with snow-blockades or blizzards, with sordid poverty and ignorant prejudices, with the ancient beldame who insists it is a case of "freemason of the bowels," with the niggardly policy of poor-officials, with conflicting engagements which you are unable to cancel by telephone, with innumerable difficulties which tax your resources to the utmost. You must decide whether your patient has a better chance in being jolted in a Ford truck to the nearest hospital, or in a farmhouse operation with a nurse to give the ether while you operate single-handed.

Here the country surgeon is a law unto himself, and these wise men that prate foolishly are prone to make us lose what

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little religion we may have. The extremist says, from the lofty position of a well-equipped hospital, that every case of appendicitis should be operated upon immediately. *Should* be, we admit, and how? The extremist, in a laudable effort to show the general practitioner the error of his ways and to save him from the wrath to come, indulges in dogmatic assertions without qualifying them and fortifies them with brilliant satire and sarcasm. He should go into the woods and commune with himself. After reflection, it may dawn on him that he is only a man after all, possibly not a very big or broad-minded one. To differ *from* a man is relatively easy. To differ *with* him requires a measure of grace and understanding.

We had a sanctimonious old lady in our town who, after deploring the ruin done to her garden and the crops in general by a period of excessive drouth, added as an afterthought, "But we mustn't complain. Poor God. He is doing the best He can." Let us fervently hope that we are all doing the best we can, sometimes under extremely trying conditions where the interests of the operatee, rather than those of the operator, are paramount.

I have many times been compelled, much against my own inclinations, to treat cases of appendicitis by means of icebags and the administration of opiates. Beneficent and saving surgery is infinitely preferable when this is possible. Ice may, however, control in some measure the inflammatory process. Opium in full dosage relieves the pain and controls peristalsis. The patient lies quietly with the intestinal coils packed closely against the caecum and appendix. They are not round tubular coils but more or less flattened, faceted coils, pressed together by rigidly contracted abdominal muscles, later by tympanitic distention, fitting each other without interspaces, while nature has an opportunity to localize the peritonitis and throw out a saving plastic exudate. The inflammation may gradually subside. The patient will still need an appendectomy, but later the conditions may be more favorable.

On the other hand, the giving of a cathartic increases peristalsis and may do irreparable damage. If there is any possibility of appendicitis, the physician should be called in before a laxative is given.

But "opium masks the symptoms." This is true. Much wisdom may be condensed in an epigram, but reverse it and it may be equally wise. A nervous or hysterical patient, whose abdomen is hyperaesthetic, needs an opiate, after which a tender McBurney's point may stand out clearly, or a Murphy's sign may show a cholecystitis. When the symptoms are masked by opium, one must ever bear in mind the likelihood of perforation or gangrene. A drop in temperature without a corresponding reduction in pulse-rate should be an urgent indication for immediate operation. It must be remembered that, in children, an attack of appendicitis is usually suppurative from the start and that comparatively few such cases subside or "blow over." The treatment of an acute appendix under the conditions here alluded to, is a matter of judgment, of the very best judgment available in the individual case, taking all the attendant circumstances into consideration. Such judgment should not be held in abeyance, should not be limited in its application by an inelastic and arbitrary rule.

In the handling of cases where perforation or gangrene had already occurred, it was formerly my practice to get these patients to the hospital by the best means available, exercising every precaution to avoid undue jolting. The mortality was exceedingly discouraging. Anyone who has ridden over a rough road at night, lying on his back in a Pullman berth, will realize what jolting may do to thirty odd feet of intestinal tubing, in the way of churning up infective material in an abdomen where it may not be shut off by a plastic peritonitis. Many of my cases were practically moribund when they reached the hospital. Far too many of them died later of septic infection from a general peritonitis. Here the best of surgeons are often helpless and unable to avert ultimate disaster.

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If it is necessary to move the patient to the hospital, it is my firm conviction that the upright position in a taxi is less dangerous to the patient than the flat position on a cot in an ambulance since infectious material will tend to gravitate to the pelvis where there is infinitely less danger of its doing serious damage.

Of late years, I have changed my attitude toward such cases. Most of my mild and practically all of my interval cases still go to the hospital, since they can be transported with safety and conditions will be far more favorable in the hospital in many respects. Cases of perforation and gangrene I operate on in their own homes, with gratifying results. The difficulties encountered in such emergency operations in the country home and in the absence of skilled assistance are not here minimized. The chief difference, however, between the difficult and the impossible is often that the latter requires more time and effort. Occasionally we find someone who is just naturally such an earnest fool that he doesn't know a thing can't be done and he simply goes ahead and does it. On the other hand, it may require courage of a high order, occasionally the courage of desperation.

I now give these cases a full dose of morphia, go back to my office, sterilize my instruments, pack my leathern gipsies, secure what help is available and return. Sometimes it is another doctor, frequently it is a trained nurse, usually it is my wife, occasionally a dentist, more rarely it is some layman who, to my knowledge, has the nerve and the intelligence to do exactly as he is told. Of such is (one section, at least) the Kingdom of Heaven, if I'm not mistaken.

I lift my patient from the bed to the kitchen table with the utmost gentleness, and operate. In contrast with the results of the plan formerly followed, my mortality is insignificant. These cases do remarkably well. When we send our easy cases to the hospital and operate at home on the bad ones, we naturally come in for some severe criticism at the hands of the dear public. That has long since ceased to

trouble me. The laity are given to contrasting the long convalescence of these drainage cases with the swift recovery of those who journeyed to the hospital and had an interval operation. To them an egg is an egg, and an appendix operation is an appendix operation. They forget that some eggs are in such an advanced state of decomposition, having reached a ripe old age, that they are practically a total loss, their chief remaining use being to express our opinion of certain public speakers. What does it matter so long as the morning stars still sing together?

We recently had a perforated appendix in a child living at a farmhouse some ten miles distant from our office and about twenty from the nearest hospital. The roads were at their worst in late November, rough, rutted, frozen, bad enough at their best in midsummer. The nearest neighbor was a mile or more away. To transport the child, in the condition in which we found him, to the hospital, would be the easiest way out for us, and in all likelihood a swift way out for the boy. There were two small kerosene lamps and a stable lantern available as lights. We operated at ten o'clock that night, using a flashlight for direct illumination, and the child had an uneventful recovery. I cite this merely as a typical case. Conditions might have been far worse, as I have had occasion to know. A good flashlight with an extra set of batteries is frequently a God-send in a large variety of conditions encountered in country practice. The immediate repair of a lacerated perineum in a private house in the middle of the night presents no serious difficulty if one has a good flashlight.

You may differ with my views on this subject. If so, I am sorry but unrepentant. These observations are not intended to apply to the city physician with expert surgeons and a well-equipped hospital at hand. On the other hand, some of the absolute and unqualified laws laid down by the hospital surgeon cannot be made to apply to the country doctor who is confronted with very different conditions. We should

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avoid intolerance and concede to others the right to their own opinions. Ovid's phrase, "*Discors concordia*," here applies. At the worst we can agree to differ.

"Tom Hall stood up by the quarter rail,
'Your words in your teeth.' said he.
'There's never a law of God or man
Runs north of Fifty-three.' "

—*Rhyme of the Three Sealers*

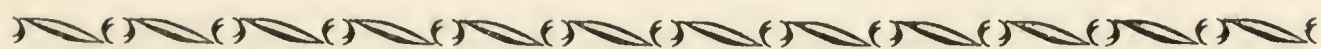
We live within one-half mile of the Canadian border, Latitude 45, so we occupy a middle position. Just half-way between the equator and the North Pole, to be exact.

It is now a far cry from the day when, as a ten-year old boy, with the firm belief that I was committing the unpardonable sin, I spent the greater part of one day hidden, with my beloved black cat, in the loft of our barn. A man in our neighborhood had "inflammation of the bowels" and they were seeking a coal-black cat, at that time the only certain and infallible cure for peritonitis. What a relief when I learned that another negroid feline had been found, split open and skilfully applied to the distended abdomen! What a load off my immature conscience when, despite my wickedness, the man eventually made a good recovery!

I once did an appendix "operation" which must have come within hailing distance of establishing a record for speed. I made a ten-mile trip over almost impassable and impossible roads, going the last mile on foot, to see a young Indian with an abscess in the right lower quadrant of the abdomen. I could not make a second visit, could not move him to a hospital, had only my buggy case with me and found that my chloroform bottle had been broken. I dropped a spoonful of aromatic spirit of ammonia on the inhaler, made a swift incision with a scalpel and evacuated the abscess which contained two fecal concretions in the remnant of an appendix which had sloughed off. I later heard that he promptly recovered.

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Back in the gay '90's some of our surgeons became so enthusiastic over the brilliant results they were obtaining that they laid down the law that "every case of appendicitis, without exception, should be operated on at once," an extreme position obviously untenable. I took issue with this and a heated controversy in the *Medical Record* followed. The only real body blow I got was when I stated that what we wanted was not an arbitrary and inelastic rule but some advice as to when and under what conditions immediate operation was imperative. Dr. Robert T. Morris said that "when all was said and done the only way was to go in and take a look at it." I have yet to find any appropriate answer to that one.

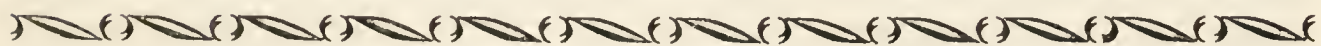


LXIV

SPINA BIFIDA

“I heave a sigh of compassion.”

WODEHOUSE



IN OBSTETRICAL practice in the rural sections, we not uncommonly meet with cases of spina bifida. In many of these, the sac is so thin that it ruptures during labor; in others rupture is imminent, and the only hope for the child is immediate, or at least very early, operation. New-born babies of low vitality, of obviously imperfect and arrested development, commonly having other congenital defects and malformations associated with the spinal conditions, tainted with tuberculosis or syphilis, are poor surgical risks. They do not bear any too well being taken from the mother's breast, transportation to some distant hospital and the addition thereto of a grave surgical operation. Many of these cases are, in the light of our present knowledge at least, inoperable. As we encounter them in general practice, a large proportion may properly be classed under the head of obstetric emergencies.

Spontaneous cure may occur; I have met with one such case, but it is very rare and rupture followed by a septic meningitis and death is the rule in cases left to nature. The mortality is so great that even a desperate operation, under conditions none too favorable, is imperative if it offers a reasonable hope of ultimate cure. I have been accustomed to operate upon these cases in country farmhouses and with a large measure of success. I believe that at one time long ago I held the record for a series of successful cases, a record which, of course, has since been surpassed by some of our large hospitals, now that operation in these cases has received

the approval of the profession generally, an approval too long withheld. In an article which I published as far back as 1909, I laid down certain rules which I then followed, and which in the light of later experiences, I still believe hold true.

1st. It is to be remembered that these patients are small, feeble, defective infants, and it is of prime importance that they be kept warm during the operation. These little ones chill down readily under ether and the operation is often tedious and difficult.

2nd. Before opening the spinal canal, the head should be lowered and the pelvis raised so that too sudden evacuation of the cerebro-spinal fluid shall not unduly lower the intracerebral pressure by emptying the ventricles.

3rd. All nerve filaments, no matter how small, should be preserved so far as possible, and if it is found impracticable to dissect them free, no hesitation need be felt in dissecting up the inner layer of the meningeal envelope and returning it, in a crumpled mass if need be, to the spinal canal.

4th. The flaps must be dissected up and freed sufficiently to cover the defect without undue tension. Lines of incision of layers should be staggered.

5th. Too much in the way of osteoplastic resection of the lateral arches should not be attempted. It seriously complicates matters, is usually unnecessary, and nature may be trusted to develop the parts and close in the defect.

6th. All hemorrhage must be guarded against, as these little patients do not stand much blood loss, and hemorrhage should be completely arrested before an attempt is made to close the wound.

7th. The suture lines must not be superimposed, in order to guard against leakage and possible infection of the cerebro-spinal fluid.

8th. The wound should be hermetically sealed by the application of acetone-collodion. A very thin, almost invisible film of absorbent cotton applied to the wound before completing the application of the acetone-collodion adds greatly

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to the strength and guards against cracking of the film. A cocoon dressing over this gives additional protection.

If one is absolutely sure of his technic, no fear need be felt of thus hermetically sealing the wound. The case will heal under the one dressing. The danger is from without rather than from within. Those who have operated upon infants in private houses will appreciate the dangers from infection by soiled diapers or the meddlesome and omnipresent old woman. In a case of this sort, there is as much need of a cumbersome gauze dressing as a hen has for an upper plate.

As previously stated, these are frequently emergency operations and better results can be obtained by immediate repair. There will necessarily be a serious mortality from any one plan of treatment, but in the presence of serious congenital defects, I sometimes feel like old Judge Priest, when Doctor Lane remonstrated with him for coming into the doctor's office with muddy shoes. "Anything that happens to that carpet of yours is for the better, I'd say," said the Judge. A fairly perfect example of the retort discourteous.

So far as doing a strictly aseptic operation in the average farmhouse, I think the difficulties are overestimated. Shortage of trained assistants is the worst handicap. Other things being equal, we get most excellent results. With a portable sterilizer for instruments, sheets and dressings and a good light, skill and courage can accomplish much. I do not believe it is wise to remove floor rugs, to take down curtains, to sweep the floor or to dust the room in these emergency operations. You are bound in so doing to raise — well, something objectionable, at least. The farmhouse kitchen or living-room has more germs in it, or at least more dirt, than the operating room in the hospital, much more, we will freely concede. This is largely offset by the fact that the germs in the ordinary farmhouse are not usually pathogenic or disease-producing, and even if they are, the inmates of the house have doubtless acquired a measure of immunity to those which

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are present. In "clean" cases, such as interval operations on the appendix, in herniotomies, amputations following accidents, removal of tumors, etc., in the absence of pus and infections, we do not hesitate to close the wound without drainage, allowing it to heal under the first dressing.

In the early days of my practice I *had* to operate on major cases at their own homes or, in utter mental agony, stand idly by and watch them die.

One time on shipboard after a severe storm in which many had been injured, as the only available doctor, I laid aside my incognito and with the assistance of my wife, sewed, splinted and strapped the injured. On the following day a gentleman in the smoking room asked me seriously if I never felt the fear that I would sometime lose my nerve. With equal seriousness I replied that of late years I had never felt such fear. Why?

One night I was compelled to operate single-handed on the one person who was of all people the nearest and dearest to me. That dark night I walked through hell, but by the grace of God, I was enabled to walk back through hell, back where the sun shone.

One eminent surgeon, whom I knew well, was in the deep wilderness. His son was stricken with acute appendicitis. He operated upon his son with the utmost care and skill but badly handicapped. His son died and the next time I saw him he was a changed man. He had walked through hell — unsuccessfully, and died not long after. What a pity! What a tragedy!

LXV

FROSTBITE

“The truth in its proper use.”

MOTTO OF THE *Wall Street Journal*

MANKIND has a certain characteristic of *ovis aries* and medical men are no exception. I refer not to any lamb-like quality but to the tendency of the flocks to follow their leaders for weal or woe. We are too apt to accept well-established and time-honored views, customs or opinions as absolute facts, provided only that they have the sanction of accepted authority and particularly if these views are not disputed and are mellowed and seasoned as the years are stored away. We occasionally cling to antiquated ideas and habits tenaciously; we accept them without question and without reflection, simply because they are orthodox and established methods of procedure.

For many centuries — just how many I am not yet in a position to recall — the classical and accepted method of treatment, in cases of frostbite, has been to rub the frosted member with ice or snow. Such methods of procedure are not only advocated at the present day by the majority of our eminent writers on surgery and accepted without comment by the profession but the same opinion holds almost universally with the laity. Some thirty years ago I wrote an article, which appeared in a Philadelphia medical journal, in which I questioned the advisability of this method.

When I was seven years of age, we lived near a little brook. One winter day I chopped out a small piece of ice from this shallow and frozen brook, containing a diminutive minnow embedded in the transparent ice. With child-like curiosity, I carried the piece of ice to the house. The ice

presently melted and, to my astonishment and delight, the minnow began to flop about vigorously in the little pool of water so formed. As I recall the incident, the minnow was about an inch long and as delicate and fragile as a butterfly. I put him back carefully into a deeper place in the brook.

Dr. Robert T. Morris, writes me of his younger days when he used to spear eels in winter. "They would freeze as stiff as ribs. When I got them home in a warm kitchen they would thaw out and chase the cook."

Treating frostbite later in life, I reflected on what would have happened had I, with the best of intentions, rubbed the minnow with snow to take out the frost. This will not tax your imagination unduly if you have ever handled minnows. It will be fairly clear to any normal mind that something very similar must happen to a frozen ear subjected to the same treatment. Aside from the fact that warm-blooded animals do not survive serious freezing, it seems evident that freezing in itself is not necessarily destructive to animal tissue. Those of us who are familiar with the effects of extreme cold know that fish and other cold-blooded animals can be frozen stiff and brittle and will still survive if thawed out slowly and gently. Why, then, should inflammation, edema, swelling, cyanosis, venous stasis, ulceration and gangrene follow frostbite in the human kind?

It is a common custom in this North Country to buy a quarter of beef in the early winter, to cut it up and allow it to freeze and to thaw a piece out from time to time as household demands indicate. What happens to a piece of frozen beefsteak if you rub it and bend it? You hear a fine crepitant sound, feel the fibers snap. The meat does not break. Even a good tenderloin is capable of standing fairly hard usage. That which happens to the frozen minnow if rubbed, happens likewise to the frozen beefsteak and that is precisely what happens to the frozen ear when treated in like manner.

The ear does not break off as a whole for the skin is tough

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and leathery and remains apparently sound, but countless little breaks appear in and beneath the skin. Numberless minute capillary vessels are ruptured. A multitude of delicate nerve filaments are torn. Through uncounted little leaks in the blood-vessels, serum is poured out. The lymphatics, whose function it is to take up waste products are rendered useless at the time of need. Veins and arteries are cracked and torn, muscle fibres lacerated, the innervation of the part destroyed. Is it any wonder that, on the following day, the ear is swollen, red, semi-translucent, painful and edematous, that inflammation or destructive processes frequently supervene? Is it surprising that the man who has unwittingly walked upon a frozen great toe and, when the discovery of his condition is made, has had his boot forcibly removed and his foot rubbed with snow, may possibly require a toe amputation?

There may be much truth in the dictum that a frosted member should not be exposed to direct heat. That sounds suspiciously like common sense. Be this as it may, I have frequently frozen my ears, my face and my fingers. When I freeze my ears, I simply place my warm hands over them and "unfreeze" them. I suffer no more serious consequences than a moderate itchiness and a sense of heat in them for a day or two.

The first time I had occasion to try this method, it was not a matter of courage of conviction solely. Some thirty-five years ago I was called out to a distant farmhouse on Christmas Eve. I was riding a high-strung saddle horse over a high and bare hill in the face of a bitter gale. Before I realized it my ears were badly frozen. I knew my horse would not stand in that icy wind; the snow was full of frost, the cold intense; I feared that, if I dismounted from the saddle, I would be unable to hold my horse and thaw out my ears in the accepted fashion without freezing my hands in addition. So I took a chance on my own personal belief, removed my fur riding gauntlets and covered my ears with my warm hands until

circulation was restored, presently arriving at my destination. On the following day I found myself practically free from the customary results of a frozen ear. After this, I have made it my usual practice to thaw out frozen parts in this way.

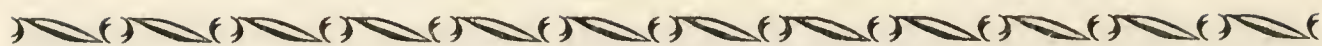
As a result of repeated experiences along this line, I am fully convinced that there is neither rhyme nor reason in the common practice of rubbing a frozen member with snow. I do not believe that the gentle application of snow does any damage, but rubbing or manipulation is to be avoided. An eminent surgeon, one of my personal friends, lost his life by this procedure. He was frostbitten and subsequently died of tetanus, presumably from rubbing with infected snow. At any rate, I am convinced that it is high time for the profession to discard an idea which is a relic of the days of charms, sorceries and incantations, a legacy from opaque minds groping in the dark. The public should be taught that their well-meant efforts are misdirected and are apt to prove destructive. Why follow like sheep simply because the path is well trodden? I have about as much respect for the usual teaching in regard to frostbite as the old Scotch-woman for the sermon of the young minister who was on trial. When asked her opinion she said, "Och, he read his sairmon; he didna read it weel and it wasna worth the readin'." The application of this may be left to the reader's judgment if he has it handy and it is in good working order.

As regards treatment, other than this, I have little to say. One must be guided by general surgical principles. One word of caution, however. Amputation should not be undertaken too soon in cases of severe frostbite or those that have been mismanaged. This not only because the vitality of the parts adjacent to the line of apparent demarcation may be still low, but because the gangrenous condition may be limited largely to the skin, the deeper parts not being so seriously involved. Regeneration of epithelium may help save a useful portion of a member which otherwise may be needlessly sacrificed. As with a burn, sloughing tissue may be removed

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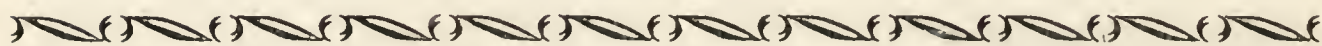
but no part needlessly amputated until the necessity is proved beyond a doubt.

Sometimes it occurs to me that our medical craft might profit occasionally by a brief sojourn in fresh water to remove a few barnacles which may interfere with swift progress. How tenaciously we cling to some of our pet medical and surgical delusions!



LXVI

BALDNESS



THE professor of dermatology, to whom I listened with more or less rapt, or rapped, attention as a medical student, said that while Faith was commonly pictured as a wave-swept female figure clinging to a bare rock in mid-ocean, a better representation would be a man industriously rubbing in a hair-restorative prescribed for him by a bald-headed specialist in skin diseases. At this time, I was already bald, and I offer this as an alibi if my remarks seem to render me subject to similar side-swiping criticism.

We have a family in our town in which mother and father are first cousins. The children are all bald, entirely bald, from infancy. We have baldness from alopecia areata, from syphilis, from typhoid, from various nervous and other disorders. Practically all the cases of baldness with which we come in contact, however are of a different type, the baldness of the male in the civilized races. Women—and, well, savages in general—are exempt. Women occasionally do become bald, but not in this way. Men wear tight-fitting hats. Women (until very recently, at least) do not. Results do not merely happen, they are brought about. Men's hats are made in standard sizes, and to fit the *average* shaped head; they are commonly heavy; they are windcatchers; they must fit snugly or we afford the street arabs much merriment. Our caps are nearly or quite as bad. Note the area of masculine baldness, how closely it corresponds with that covered by our headgear. See men take off their hats to relieve that slight frontal headache. Note the perspiration on top of the head, if it is bald. Notice the mark of the hatband on the forehead. Observe that he has an atypical head, that the ready-made hat, suit-

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able perhaps for the average person, is too short for him, and the heaviest pressure comes on the forehead, compressing the veins and arteries, the nerves and lymphatics. The remainder of the circumference is protected, in large measure, from injurious compression, by a cushion of hair. Notice that the long-headed man's baldness begins at the forehead and works back.

A noted doctor of divinity once asked me to explain why he and three of his sons were so bald while the fourth, an elderly district attorney, had a magnificent head of hair. I merely suggested that they note the shape of each other's heads and try on each other's hats. So far as hereditary baldness was concerned, the district attorney had a head shaped like his mother's. This looks so suspiciously like common sense that it doubtless will not commend itself to a certain type of dermatologist.

What is the remedy? To wear hats as little as possible, to remove them frequently, and thereby acquire a reputation for courtesy. To have them of light weight and soft. To provide ventilation. Above all, to get a piece of corn felt at the drugstore. Cut from this two pads about $\frac{3}{4}$ of an inch square. Moisten the gummed surface of the pads and stick on the inside of the hat under the sweat-band where they will not be seen, at the front part of the hat where it comes in contact with the forehead, decentering each pad about an inch from the midline, or in other words, spacing them two inches apart. In this way, pressure on the main vessels, which run up on either side close to the midline, will be relieved without encroaching on the territory of the temporal vessels. Get your hats a half size or a quarter size larger, if need be. Fix all your outfit of hats and caps in the same way. Don't waste good money on hair restoratives. As for wearing a wig, this may be advisable in some cases, but in others, to use the English phrase, it simply is not done, not cricket.

For those unfortunates who are already bald, I can offer little comfort. I follow Dr. Jenkins' idea. He was called to

see the Condon family, all of them being ill with influenza save Big Bill, who had driven ten miles to get the doctor and who had to drive him back on a cold winter night. The doctor made the rounds, prescribing for all of the household, and had gotten himself well bundled up to face the bitter weather when old Mrs. Condon, who ruled her household with a rod of iron, called to him, "Come back here, Doctor, and tell us what we shall do for Willum."

The doctor picked up his vial case, smiled and said, "Use him well, Mrs. Condon. Use him well," and departed.

When one of these patients with a bean as bald as a bituminous boulevard and shiny as a brass door knob on Easter morning, asks my advice, I try to use him well. I advise him that baldness is not serious so long as it remains strictly superficial and recommend that he cultivate the gentle art of doing without. Cold comfort, perhaps, but it is the best I have found in my own case.

The statistics of Jackson and of White seems to show from thirty to forty percent of this type of baldness which is distinctly hereditary. I do not question the accuracy of their statistics, but I have already called attention to the shape of the head as the chief factor in this "senile" baldness. It seems reasonable to suppose, in the absence of statistics, that the *shape* of the head was hereditary in from thirty to forty percent, rather than that the baldness was hereditary and only manifest in those past middle age. The weight of opinion seems to be that the chief factor is dandruff or seborrhoeic dermatitis. If this be true, why are not women prone to *this same* type of baldness? Why does the bald area conform so closely to the area covered by the hat? Are women free from or immune to dandruff? As for dandruff, I believe that Dr. Guillotine invented the quickest and most permanent treatment of which I am aware.

Some writers attribute baldness to evolutionary changes. Are women wholly exempt from evolutionary progress? At least one, if not more, of our authorities claims that bald-

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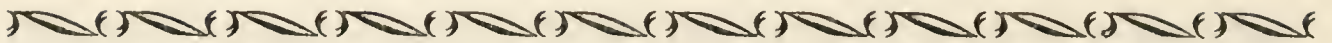
ness is due to loss of subcutaneous fat, shrinkage of the scalp with the pressure manifesting itself, as might be expected, chiefly on the top of the head, this being followed by atrophy of the hair follicles. This might be a possible, even a plausible, explanation of the gradual thinning of the hair in many elderly women, but why does not this same thinning occur in men rather than the total baldness confined to the hat-bearing area?

In alopecia areata, I have had, apparently, much success with the following prescription:

| | | |
|----|-----------------------|---------|
| R/ | Bichloride of Mercury | gr. xvi |
| | Resorcin | dr. vi |
| | Alcohol to make | oz. xvi |

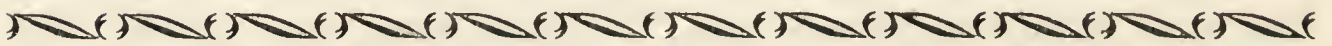
Sig. Rub well into the scalp every third day.

Since there is a natural tendency for these cases to recover in the course of time, it is a question whether this treatment had much to do with the recovery which occurred; further, deponent sayeth not.



LXVII

FOOT TROUBLES



TAKEN by and large, a very large proportion of our foot troubles is due to our shoemakers. Naturally, they cater to the public demand and the dear public knows little of what is really needed, and often cares less. So long as men pick out shoes whose natty appearance appeals to the eye, so long as women buy footwear as they buy autos, to match their Easter bonnets, just so long will we have fallen arches, bunions, Morton's toe, corns and other troubles. In that sense, we, too, are responsible.

The foot-arch specialist confronts us with cases where we made a diagnosis of rheumatism, and he relieved the patient with a proper-fitting arch support. On the other hand, rheumatism is not only capable of producing swelling and softening of the ligaments and subsequent deformity, even when no special strain is present, but it has an unholy tendency to locate in the weak spot. Frequently, more than one factor is at work. Given a person with a slender foot, who, as the years roll on acquires excessive fat, who, in other words, has Chippendale supports for a Chickering superstructure, add to this excessive strain from too much standing on the feet, or similar causes, and a rheumatic tendency, it is small wonder that the arches fall.

When it comes to picking out shoes, a few points must be borne in mind if we regard our own comfort. So long as heels, and particularly high heels, are worn, the feet rest on inclined planes with a natural tendency to slide forward into the toe of the shoe. The only means to combat this tendency and avoid crowding of the toes is to have the shoe fit snugly over the instep. Merely using a longer shoe will

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not serve, though it will help, and a long shoe looks far better than a short one. Those who have a low and slender instep are most apt to be misfitted by the average shoe. Buttoned, buckled, zippered shoes and those without an instep strap, are unfit, the reason being that they cannot be adjusted to grasp the instep properly. Laced shoes of the Blucher, or similar type, are efficient, provided always that when first fitted there is a broad space between the eyelet flaps which will be taken up by the lacing as the shoe stretches under use. If these flaps meet or nearly meet when first fitted, it will be impossible to keep the instep snug as the shoe stretches, and they will be no better than the other types referred to. Laced shoes have always been in use and will continue until we find something better.

If one will take the trouble to stand a child who has never worn shoes, in a dusty road or other place where the footprints will be clearly visible, he will see that the two pedal extremities, taken as a whole, are similar to a split column, *i. e.*, the inner borders are straight and parallel with each other while the outer borders represent the sweep of a half circle. Hence the necessity of what is known as the swing last.

Our shoemakers are prone to make their shoes comparatively straight instead of thus curved, the result being distorted feet and disability with attendant pain and discomfort. A pointed toe on the shoe is not necessarily injurious. If the points are so placed that they come together when the feet are parallel, and the shoe is not too short, they can do no harm. If, when the shoes are placed parallel in close juxtaposition, the points of the shoes diverge materially, the great toe, having, like the thumb, a good deal of lateral movement, is crowded over and the shoe pressure comes over the great toe joint. Instead of being exerted on the lateral aspect of the joint, the pressure is thrown, as it were, on the opened joint, with resultant irritation and tendency to bunion formation. The smaller toes may be forced to overlap and likewise become deformed. Unless the foot is already

so distorted that a properly shaped shoe will not fit, get a shoe built on a swing last.

If the shoe does not fit snugly over the instep, corns are almost inevitable, owing to the constant friction and slipping of the foot within the shoe at each step. It is not a tight shoe that causes corns and bunions, but a badly fitting one.

A corn is readily removed by means of a sharp fish-bellied scalpel, if it be borne in mind that the corn is shaped like a double cone. Lateral pressure between the two fingers will force up the submerged apex of the lower cone and enable one to remove this part which causes the pain. If an accidental wound is made, it should be immediately touched up with iodine or the half-strength lunar caustic stick.

Dr. Robert T. Morris says that one patient from whom he removed an ovarian tumor was far more grateful for the soft corn removal than for the loss of the tumor.

Years ago, during midwinter grip epidemics, when I was constantly getting in and out of my sleigh in making calls, I suffered greatly from chilled feet, lacking time to remove and put on arctics every time I entered a house. Wearing high arctics for many hours at a stretch, my feet would naturally perspire and become chilled. I found that simply dusting the inside of my socks with equal parts of boric acid and talcum, two or three times a week, effectually checked the perspiration and kept me from the discomfort of cold feet. I found out, later, that the habitual use of this powder effected a great saving in shoes since the greatest foe to uppers and stitching, the dampness, was done away with. Between street wear, fishing and hunting, I now find that I commonly wear out five pairs of soles before the uppers or the stitching gives out.

This powder promptly relieves those who are troubled with offensive foot odors. One of my patients told me, apparently in all seriousness, that instead of being compelled to change his socks daily as heretofore, he could now wear them until they were worn out. The wisdom of making

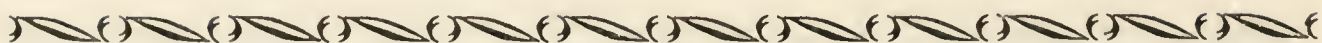
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public this last statement is, perhaps, open to doubt. Since, however, the only comfortable way of seeing some of these patients is through a telescope, I have decided to risk it.

Cultivate the habit of wearing shoes with reasonably heavy soles, if you want comfort. The moccasin is a poor thing to travel in for any length of time unless you have long been accustomed to them. True, the Indians used them but they were a poor substitute, in many respects, for good serviceable shoes. Lo, the poor Indian.

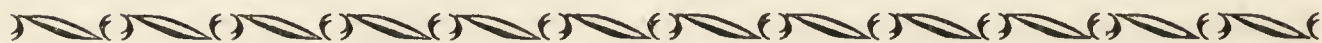
When one is troubled with chilblains, it is usually recommended that loose woolen hosiery be worn. With some people wool aggravates the trouble. I have no explanation to offer. I simply know that this is true in certain individuals. A mixture of camphor gum, methyl salicylate and oil of eucalyptus, equal parts, makes a good local application for chilblains. The possibility of symmetrical gangrene (Raynaud's disease) should be borne in mind.

All this may not be so exciting or so — so picturesque as journeying to Williamsburg, Ont. and having a miracle performed for a dollar a twist, but it sounds rather reasonable, don't you think?



LXVIII

MORTON'S METATARSALGIA



MORTON'S painful toe was referred to about 1860 under the title of pododynia, but the first reasonably accurate description of it was by T. G. Morton, of Philadelphia. Since the publication of his article in 1876, various writers have attributed the trouble to gout, periostitis, breaking down of the transverse arch of the foot and a pinching of the superficial branch of the external plantar nerve with its two digital branches.

The patient afflicted with metatarsalgia tells you that the pain comes on suddenly, usually when wearing some particular shoe. It is brought on by exertion, walking on rough ground, or by a chance misstep. In a well-developed case, he tells you that the pain is neuralgic in character, accompanied by numbness and tingling and a burning sensation like that which follows a bruise of the ulnar nerve at the elbow. He locates the pain in the sole of the foot, from the metatarso-phalangeal joint forward to the region of the fourth toe. Lateral pressure aggravates this pain. He can work his foot back into shape again by taking off his shoe, pressing upwards on the joint, at the same time flexing and extending the third and fourth digits to the limit of comfort; then he hears a light snapping sound, feels something slip; the pain is immediately relieved and soon disappears entirely.

It seems to me that he makes a clear case. This is not the history of periostitis, of neuritis or neurofibromata, of gout, of neuralgia, or of breaking down of the transverse arch *per se*. It is the symptomatology of a subluxation of the distal end of the metatarsal bone, with pinching of the external branch of the plantar nerve which accounts for the definite location

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of the pain and its peculiar character. As soon as the distinct snap, following reduction of the subluxation, is felt and heard, lateral pressure causes no discomfort. As schoolboys, it was a favorite trick to "get the grip" on the other fellow. This was done by pressing down the third knuckle of the hand with the thumb and gripping the hand tightly as in handshaking. An unbearable nerve-pain was the result. In Morton's toe, we have an analogous condition.

As regards treatment, liniments, counter-irritants, and the like, are useless. Sayre's treatment, by gouging out the sole of the shoe, may give relief but seems illogical. Excision of the nerve, or of the head of the metatarsal, in the vast majority of the cases, is wholly unnecessary. In my experience, arch supports, even with the metatarsal hump, or those made to order from a plaster cast, have been unsatisfactory. Replacement of the subluxated metatarsal, followed by a snug strapping of adhesive plaster around the ball of the foot to prevent recurrence, has been effective, but is open to some objections. Unless carefully applied, the adhesive is uncomfortable, sticks to the stocking, becomes unsightly and offensive. Elastic appliances, often called arch supports, give some relief, but are prone to give way under any strain and allow displacement to recur.

For immediate relief, removal of the shoe and stocking, elevation of the transverse arch combined with forcible backward extension of the third and fourth toes and a little manipulation, will readily reduce the subluxation in nearly all cases. Usually this is accompanied by the distinct snap referred to. If lateral pressure no longer causes discomfort, it will be evident that the bones are replaced and the nerve disengaged.

For the after-treatment, use a long, narrow, close-fitting shoe made on a swing last, with a fairly heavy sole, Blucher type, laced. Many cases get relief by building up the inner half of the sole and heel of the shoe, a procedure which is likewise effective in other types of fallen arches. As a rule,

it is well to avoid broad and loose shoes. In putting on the snug-fitting shoe recommended, care must be taken that the subluxation is reduced, otherwise the lateral pressure of the snug-fitting shoe will only maintain the subluxation and aggravate the pain. It would be akin to putting on a truss without first fully reducing the hernia.

The remedy for Morton's toe is to get shoes that fit properly. As the shoe stretches under use, the trouble may show signs of recurrence. The first thing to do is to put in a half-insole, one that runs from the heel forward to a point just back of the ball of the foot. This should be "skived" down thin at the anterior edge and held in place by a small brad at the extreme heel end. Such an insole tightens the shoe without unduly filling up the anterior portion.

Another device which I have had in use many years, and found extremely effective, consists of a band of firm but thin calfskin about three inches in width and in length lacking about three-quarters of an inch of the circumference of the foot. A series of holes is punched in each end for adjustment by laces on the dorsum of the foot. To prevent the device from slipping forward toward the toes, a simple loop of corset-lace or flat shoe-lace is sewed on about a half inch from either end. This should be just long enough so that it can be slipped above the heel and across the tendo achillis when the leather band is in position. The first time it is used, it should be thoroughly soaked in water, then snugly laced either over the foot or a suitable last. Once dry, it will hold its proper shape indefinitely.

This simple appliance can be made in a few minutes at practically no expense. It has proved a great comfort to many of my patients. Most of these are adults, and excessive work on foot, together with increasing weight and ill-fitting shoes, are the chief causative factors. The leather band simply holds the foot together when the shoe fails to do so, thereby preventing displacement under excessive pressure. It is far more effective than the elastic bands and infinitely more com-

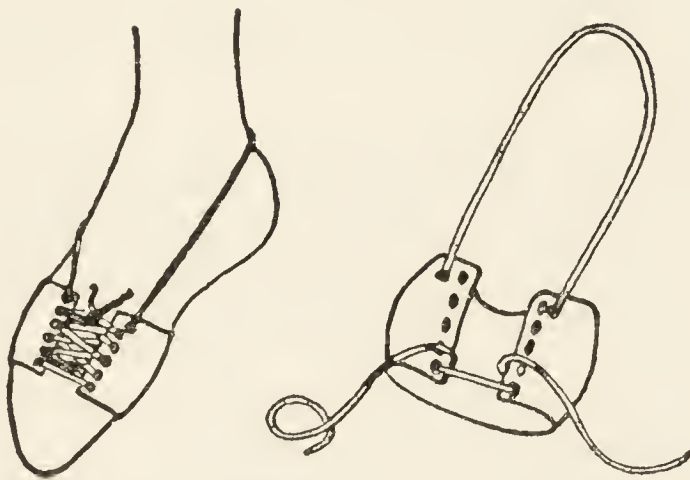
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fortable in every way than the adhesive strapping. Since the publication of this article, many years ago, various band arch supports have been placed on the market. They are comfortable but, being elastic, are prone to give way when most needed. Given sufficient time, the metatarsal pain usually disappears under any line of treatment.

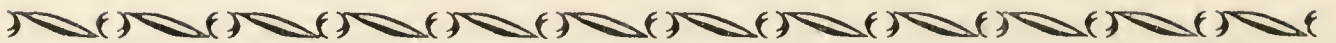
Speaking of pain reminds me of the old farmer whose daughter had been a stenographer in Chicago for some two years. At the end of that time she visited her old home and her father said, "I don't see that you've changed much, Mary. Your lips are a leetle redder and your hair's wavier, and of course you've growed some."

"Grown, Father, grown," she corrected him.

"Groan yourself, if you feel like it. There ain't a danged thing ailin' *me*."



Leather Support for Morton's Metatarsalgia.

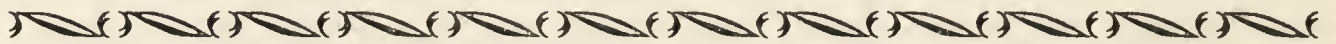


LXIX

ACROPARAESTHESIA

“He shook my hand and he shed some tears and gave me
a mean cigar.”

LOWELL OTUS REESE



LATE one summer afternoon I went in my motor-boat five miles down the Salmon River and three miles across the St. Lawrence to see a patient. It was long after sunset when I started on my return trip, a still and cloudy night with some fog. The narrow, marshy mouth of the river had no definite landmarks but I managed to enter it squarely and went up the winding Salmon, with its sunken logs, sandbars and numerous sharp bends without difficulty. As we neared the end of the journey, a friend of mine who was with me said, “How in Sherman’s definition of war do you steer up this crooked river on such a pitch-dark night? I have been expecting you would run us into the bank any minute.”

“I go by the stars,” I replied.

“But there *are* no stars,” he protested.

“Oh, yes, there are, only we can’t see them on a night like this.”

In medicine, the guiding stars are always there, but at times the visibility is poor.

The condition known as acroparaesthesia or waking numbness, although of frequent occurrence, is seldom mentioned in the textbooks, the annual reviews, or in current medical literature. The practitioner is compelled to treat these cases without guidance, groping in the dark, with more or less unsatisfactory results.

As evidence of this I may state that in the course of an extensive medical reading, the only fairly complete and ac-

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curate description of it which I encountered was given by an English physician in Braithwaite's *Retrospect* over ninety years ago. Under the head of "Waking Numbness" the symptomatic picture was well drawn, though little or nothing was given regarding its etiology or treatment.

Various writers on nervous affections refer to it briefly but shed no light on its origin or suggest anything very promising in the way of treatment. Wharton Sinkler recommends ergot in full doses, Faradism, strychnia and arsenic. Whether the condition be recognized as a distinct entity or a symptom complex, it occurs with sufficient frequency to merit more than the brief and fragmentary references which I have been able to find. That the condition is not well understood by the general practitioner seems evident from the frequency with which these patients state that they have been treated for neuritis, rheumatism, neuralgia, partial paralysis, creeping palsy, threatened shock, poor circulation and such vague ailments.

Numbness of the extremities, with prickly, dead sensations, is a common symptom of various affections of the spinal cord and of other disorders and the mention of it brings to mind visions of locomotor ataxia, syphilitic lesions of the cord, myelitis, neurasthenia, hysteria, pernicious anaemia, and one instinctively reviews all the likely causes from multiple sclerosis and peripheral neuritis to overdosage with aconite or arsenic.

Once this peculiar group of symptoms is recognized as a whole, diagnosis is comparatively easy though it must be made largely by exclusion, by the presence of subjective and the absence of objective symptoms. In other words, the patient tells you how he feels but the signs are largely negative on physical examination. There are certain features, however, which help materially in making a correct diagnosis.

The patient is usually an adult, commonly at or past middle life and usually in other respects apparently healthy. It occurs with much the same frequency in men and women.

Certain occupations predispose. It is of frequent occurrence in farmers, their wives and hired help. The patients are generally of healthy, robust, long-lived stock, occasionally plethoric. From the standpoint of the doctor, it is a good, comfortable, reliable disease in that the patients do not become crippled and there is apparently no mortality.

It is worse at night, wearing off in the early morning hours after exercise. In a typical case, the patient complains of waking in the night with a numb, dead, prickly feeling in the arms, much less frequently in the legs; if severe, more or less dull aching is added thereto. Friction relieves it for the time but it soon recurs. It seldom persists during the day. There is no anaesthesia proper, seldom any evidence of any motor or sensory paralysis; no girdle sensation, no loss of muscular power, no noticeable tenderness in the affected parts, no disturbances of the reflexes as a rule. There is no adequate evidence of spinal or cerebral disease of an organic nature and no obvious cause. The areas affected, while irregular, are commonly bilateral and usually symmetrical. When the patient greets you, one is reminded of Sydney Smith's remark anent a type of handshaking which indicates rude health, a warm heart and distance from the metropolis.

The onset is slow and gradual. There is no tremor, no disturbance of the pupils, speech or special senses. The intellectual faculties are unimpaired and the sphincters never involved. Contractures, trophic changes and vasomotor disturbances are conspicuous by their absence. There is no vascular derangement as in Raynaud's disease. Co-ordination is good and the pulse and temperature are normal. Heredity plays an important part, various members of a given family being subject to it. In this connection I have observed certain curious facts which perhaps have some bearing on its etiology.

The patient will frequently give a history of asthma, of skin eruptions of the "eczematous" type or of a peculiar gastric derangement. This is characterized by pain, sour stomach and a dry and hot sensation in the mouth and throat. Excess

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of urates is common. If the patient has not personally suffered from these troubles, one can usually elicit a history of their occurrence among his immediate relatives.

The diagnosis of acroparesthesia presents no difficulties and is made largely by exclusion. Diseases of the spinal cord and peripheral nerve affections give a very different picture. Hysteria may imitate this disorder at times but these cases, as a rule, show none of the evidences of hysteria. The early stages of pernicious anaemia may be easily confused with acroparaesthesia, but a blood examination should clear this up. The numbness of pernicious anaemia is not nocturnal and the feet, rather than the hands, are affected. The prognosis in acroparaesthesia is always good.

As regards treatment, I have only one remedy which gives me uniformly satisfactory results, this being iodide of potassium or iodine in some form, given for an adequate period and in moderate doses. A decoction of prickly ash bark is a valuable adjuvant in obstinate cases. After a year or more, the trouble is apt to recur but is again relieved by the same treatment. They return, asking for more of "that same medicine that cured me before."

The nocturnal character of the pain, so characteristic of this affection, might lead one to believe that syphilis might be the underlying factor. Frankly, I do not believe this to be the case, despite the fact that it is my rule to suspect syphilis in every chronic case until innocence is reasonably proven. A few of these cases have had syphilis but a personal knowledge of their antecedents, careful history taking, thorough physical examinations and repeated blood tests in a large number of cases, show a rather smaller percentage of syphilitic taint than would naturally be found in a like number of cases taken at random. This may be purely accidental or it may be due to the fact already noted, that these patients are usually in robust health, which is certainly not the case in the syphilitic.

So far as I can ascertain, this malady is comparatively rare

in other sections but is quite common in many places along the St. Lawrence Valley. The fact that it is prone to recur, that it yields to the same treatment, that I have found no other remedy (other than iodine) which is efficient, that the concomitant symptoms are benefited by the same line of treatment, leads me to believe that it might be a slow form of autotoxaemia. Other indications might suggest that it is due to the same iodine deficiency which is present in this locality. Again, when we read what has been ascertained regarding the water supply in the sections where "mottled teeth" are of common occurrence, it suggests still another line of conjecture.

It has been repeatedly stated by other physicians who have met with these cases that milking brought on this trouble and that it was the chief cause. While I am quite certain that milking almost invariably aggravates this condition and that the numbness is, at times, sufficiently severe in the morning to hamper milking, I am unable to subscribe to this theory. Why should it in many cases be accompanied by numbness in the legs? Why is it nocturnal? Why does it occur chiefly in those at or beyond middle age and, above all, why should it occur so frequently in those who have never in their lives been on the business side of a cow's udder? This theory seems to be as left-handed and as illogical as that of the woman of Hibernian origin who was suing for divorce. The judge asked what reason she had for suspecting infidelity on the part of her husband. Hesitating for a fraction of a second, she said, "Yer Honour, I'm sure he is not the father of me last choild."

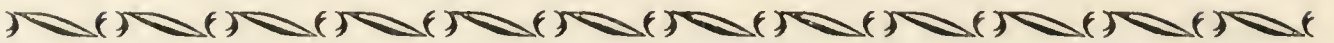
Speaking of cows makes me think of an old farmer living in Westville. His leg was broken just below the knee. After I had made the proper adjustment and the splints were in place, I re-entered the room and found him sobbing. I sat on the side of his bed and tried to comfort him. "You don't need to feel so badly about this. Your leg will be all right. You'll have to stay in bed for about ten days, at the end of

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which time I will put it up in plaster and you will be able to get around comfortably with a pair of crutches and in eight weeks you will be able to walk on it. In a year you will have to stop and think which of the two was broken."

Looking at me reproachfully, he said, "I'm not crying because my leg's broke. I can put up with that, I guess. It's just because it was a condemned cow that did it."

On the whole, I am inclined to believe that this "waking numbness" is due to the same iodine deficiency which is a basic factor in so many chronic disorders.

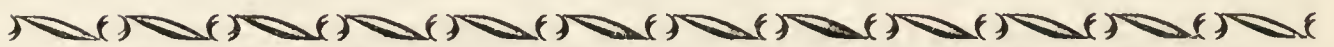


LXX

ARTERIO-SCLEROSIS

“My age is as a lusty winter,
Frosty, but kindly.”

—*As You Like It*



YEARS ago, before the sphygmomanometer came into general use for measuring the blood-pressure, we had to rely on our sense of touch in estimating the (systolic) pressure. Some of us became quite expert at it and have repeatedly surprised some of our younger brethren by first making our estimate and then letting them check our figures by the machine.

Arterio-sclerosis is merely a general term descriptive of certain changes accompanying advancing years and its equivalent degenerative processes. It is, however, convenient and useful in its way. I recall being called to an outlying town to meet the attending physician in consultation on a case which he outlined before entering the sick room, stating that he had never seen a patient with so many different diseases. His mind was affected, having an unreasonable fear of some impending misfortune, he was subject to vertiginous attacks, could not recall words when needed, was a victim of insomnia, waking in the early morning and lying awake for some hours thereafter. He had cataract, senile gangrene, angina pectoris. He suffered severely from cramps in the legs. He had high blood pressure, contracted liver and kidney, had had a slight cerebral hemorrhage and his heart was enlarged. He was growing forgetful, had hardening of the arteries, and prior to development of the gangrene, had been growing “footless.” The doctor asked me if I had ever encountered such a case and seemed a trifle puzzled when I said that they were common enough and that taking a broad view, it was all due to

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one underlying condition, being merely phases of arteriosclerosis, the only remarkable thing being that the condition was so evenly distributed. His condition was certainly deplorable, but he had at least escaped prostatic obstruction and a few other things which might have been added.

In these cases of arterial degeneration attendant upon senility, I have had better results with the iodides (sometimes with the bromides or luminal) than from any other lines of treatment. They lower the blood pressure without lowering likewise the patient's vitality. Some remedies which reduce arterial tension let us fall from the frying pan into the fire. It is better, at times, to endure the troubles that we have than fly to others that we know not of. Occasionally it is advisable to give the iodide subcutaneously or intravenously, using the ampoules specially prepared for this purpose. The iodides seem to act with more uniformity, with a happier effect on the general condition and with more permanent benefit, than many other remedies which lower blood pressure. For immediate relief, where time is of the utmost importance, as in cases of impending cerebral hemorrhage, one can always get results from venesection which will promptly reduce excessive tension. For general use, I have seen many remarkable results from a quart of Bulgarian cultured milk per diem, taken steadily year after year.

Buttermilk likewise does very well and to most of us is much more palatable. If not otherwise easily obtainable it can be readily made by setting, from time to time, a two-quart mason jar of milk in a place warm enough for the milk to sour properly and beating it up at the proper stage with an egg-beater. It does not make a buttermilk that is the exact counterpart of the old-time buttermilk from mother's churn because it contains butter and more casein, but it is far more nutritious and palatable and can be sweet, sour, or even bitter according to individual preference. A little buttermilk from the first jar added to the next will save time in the same way that a little yeast serves to start the second batch on the right road.

It is astonishing how some will go on with their customary work day after day and claim that they never felt better in their lives, while their systolic pressure is 300 mm. or over. On the other hand, other cases with only a moderate rise in tension will have a cerebral hemorrhage. This, however, is explainable on several grounds, irregular areas of congestion, local degeneration of cerebral vessels in advance of the general arterial condition and, above all, the relative resistance of the arteries in the individual case. Some people have arteries which are tough, rugged, resilient, standing abuse safely and an internal pressure which would raise havoc with arteries of poorer material. A cerebral hemorrhage, occurring in such cases, is usually severe. A high-grade tire, under heavy pressure, blows out with much greater violence than a weak casing. High blood pressure, in itself, may be a conservative process and one that should not be interfered with. On the other hand, when one who has shown a high blood pressure for a long time, develops a gradual fall in the tension, it is frequently a precursor of general dissolution due to a failing heart or general asthenia.

An excessively high tension, or a moderately high tension, taken together with other disorders such as impaired kidneys, should receive attention. Frequently, this tension is purely nervous or aggravated at least by nervous strain. Here the bromides or luminal exert a beneficial action. On the other hand, it is prone to occur in those who have broken all the commandments and then some. It is a degenerative process. The piper that played for Moses undoubtedly had it if he piped until old age set in.

Such degeneration attendant upon old age has its compensations provided the decay does not occur at the top. It should be viewed with a measure of equanimity. Florida is thronged with elderly people whose chief occupation is listening to the hardening of their arteries. In many cases, such relief from strain means a longer and happier life. As a people, we are developing the migratory habit and from year to year,

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coinciding with the development of swift and easy transportation, a larger proportion of our people is going south in the winter and north in the summer, like elderly robins. This is as it should be. It is not contended that the senile will thereby be enabled to skip like the lambs of Wall Street, or that the digger of graves will turn his spade into a pruning hook for lack of employment, but the North Country takes heavy toll of the senile arterio-sclerotic every winter. The cost of living averages much the same, North or South. Fuel bills, clothing expenses and housing accommodations are less in the South. This is offset by increased cost along other lines to some extent, and the remainder by costs of transportation to and fro. You can spend a lot of money at tourist hotels in Palm Beach and Miami, but the same is true in Adirondack and other resorts in the North. There is a distinction between spending money in pure foolishness and in poor foolishness.

The life is less strenuous in a semi-tropical clime, and to the most of us, far more comfortable and peaceful. This is one essential when blood pressure is over-high. Some time ago I discontinued a daily paper which I had taken for years, because of a change in its editorial policies. The circulation department kept urging me to renew my subscription until at last I got desperate and wrote them, "Strong emotions are not good for the arterio-sclerotic. My temperament is such that I can get boiling mad on short notice and I do not feel like paying \$18.00 per annum for a daily exciting cause."

We had a lawyer who said that his wife had the most even temper of any woman in Northern New York, that she was mad all the time. She retorted that she could say this much for Silas: he was a man who never lost his temper. He had more and more of it from week to week. That tendency is decidedly lessened in the Sunny South, where the elderly and tired business man can gradually get into the stride of idleness.

The trouble with the arterio-sclerotic is simply that he was born too long ago.

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Hard work is considered by many authorities a cause of arterial hardening. While I do not care to dispute this, I cannot avoid thinking of Great-granddame Russell. I was called in to see her one day. She was a little, dried-up and bent old lady, sitting in a splint-bottomed easy chair. Peering at me through a maze of wrinkles, she asked in her cracked voice, "Are you the doctor? Did Peter send for you? He is a foolish boy. [Peter was then eighty-two.] No doctor can do me any good. I am too old. I am played out. I worked too hard. I always worked in the fields with the men. I sawed wood and I split it. I loaded hay on the wagons and I mowed it away. I cut grain with a scythe. I dug potatoes. I always did a man's work. I worked too hard. *That's what brought me where I am,*" she wailed.

She died some two years later at the age of 113.

LXXI

CANCER

“As for me, all that I know is that I know nothing.”

SOCRATES

THE present view of cancer, and for the purpose of this discussion I use the term to include all malignant neoplasms of this group, is that it is neither contagious, infectious nor hereditary. This I would not venture to dispute. At least, not so long as it expresses an opinion and belief, and is not stated as an absolute fact.

On the other hand, we are finding, from time to time as the years roll past, that certain maladies which were formerly considered unexplainable visitations of Providence are due to definite and specific causes, to unsuspected germs. We know a good deal about malignant diseases, but some of the major facts still elude us. Meanwhile, it is best to shun positive statements and leave a loophole through which we may more or less gracefully retire should necessity arise. To say that one may inherit a predisposition or a familial tendency to cancer is but one way of begging the question. This was at one time the popular explanation of the incidence of tuberculosis in certain families. As a stopgap, for those who are afraid to acknowledge that they do not know, it has merit. It has little else to commend it.

Cancer is unquestionably of unusual frequency in some families. Whether it be due to a hereditary predisposition, to the old cellular theory, to some unknown factor in the environment, or to some unrecognized infective process which we do not even suspect, no one can as yet say with any great assurance. I have in mind one family living in the section where I have practiced for many years. I have known the

most of them through several generations. I have operated upon a number of them, chiefly for malignant growths. They are of Scotch descent, mostly engaged in farming, living on a high bluff on the banks of the St. Lawrence River. They are good, substantial, law-abiding people, thrifty, industrious, prosperous as these Scotch are apt to be. None of them, so far as I can find, is addicted to alcohol in any form, to narcotics, to immorality. In fact, I know of no large family, in the section referred to, any more free from suspicion in these respects.

Environment can be practically ruled out, since a collateral branch of the same family has lived, ever since I can remember, almost next door to them, under precisely similar conditions in so far as I am any judge, and this branch seems entirely free from malignancy. The great-grandparents and the grandparents, in so far as I know them or can ascertain their histories, were healthy and with none of this tendency. Of their descendants, I have fairly complete records, gleaned in part from my own knowledge but also in a large measure from members of the family who naturally have given the matter serious thought. My records include forty-eight descendants. Of these, two died in infancy, five died of tuberculosis. Two are now tuberculous to a moderate degree, under occasional observation of Saranac specialists. They are apparently doing well and may fully recover. Eighteen of the family have had malignant growths. Of the eighteen, sixteen are dead. One, living, was twice operated on in Montreal for cancer of the lip. At the last report he was entirely well. The other was an elderly man upon whom I operated some twelve years ago for a cancer of the face about $\frac{7}{8}$ of an inch in diameter. He has had no recurrence. Most of the surviving members of this group of forty-eight have not as yet reached the so-called cancerous age. It remains to be seen what proportion of these will eventually develop malignancy.

Intermarriage has been fairly frequent in this family, but I have been unable to trace any greater frequency in the

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offspring of these intermarriages than of those who, like Cain, went afield to procure a mate. Of the sixteen that are recorded as dead, there was shown an exceedingly distinct tendency to recurrences and metastases, in other words, an unusual and excessive malignancy. Of this sixteen, three died from metastases after radical operations for breast cancer. Three died from cancer of the stomach. This does not include a non-resident member of the family who died from a chronic stomach trouble, "probably cancerous." This was, like one other case, excluded from my records as being too vague. Two died of cancer of the larynx, both females, not using tobacco. Three had facial cancer. One of these had multiple growths which I removed without local recurrence. He died some years later of cancer of the bladder.

One died from cancer of the rectum many years after a radical operation followed by an inguinal colostomy. One from a growth originating in the thigh, the exact nature of which I could not ascertain. One from late recurrence after operation for cancer of the uterus. One each from cancer of the spine and from general carcinomatosis. It is a fair inference, in the absence of a more definite history of these latter cases, that they may both have been cases of secondary involvement. I have given the facts. I have no theory which seems to fit exactly.

I have received questionnaires from various sources asking for data regarding the incidence of malignant growths in the tuberculous and the syphilitic. I have been wholly unable to see that these cases show any particular tendency to develop cancer over and above the non-tuberculous and non-luetic. I have had ample opportunity to observe this as regards a near-by Indian Reservation. Syphilis and tuberculosis are both rampant among these people. Cancer is extremely rare in the full-blood. It is occasionally seen in the half and quarter-breeds. Taken as a whole, they are remarkably free from it.

Our knowledge is being added to daily; the diathermic

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cautery knife is an example of a comparatively recent improvement. In many cases it is better than the older methods. Our cancer institutes are bringing out new facts, through painstaking efforts. A vessel containing certain chemicals in supersaturated solution may receive a sudden jar. Immediately the contents become crystallized. We are all adding our quota to the facts regarding cancer. Some day (and let us hope and pray that this day may not be long delayed) when further observations are made, more facts established, the cancer problem will be in a similar supersaturated state and the true theory, the real cause, will crystallize suddenly in some bright mind, perhaps from some slight accidental jar. The discoverer will be acclaimed and honored for all time, as long as grass grows and water runs, and this will be his just due. Nevertheless his discovery will be due in a large measure to the collective efforts, to the careful records of proven facts and to the earnest and tireless work of a host of others who will receive no plaudits.

Years ago, when General U. S. Grant was dying of throat cancer, a quack doctor from the West said that he could cure him. The eminent surgeons in charge refused to let him see the General, whereupon the newspapers denounced them for their dog-in-the-manger attitude since, while admitting their own inability to cure him, they would not give the other man a chance. That was extremely shallow thinking.

I was young and callow at the time but I saw the fallacy of their reasoning. Either this charlatan was telling the truth or he was not. If he was merely a monumental liar seeking notoriety, why let him disturb a man who was sick and suffering. If by any possibility he was telling the truth, he was self-branded the most heartless criminal of the ages. Untold millions have died the most dreadful deaths from this horrible disease. It is stated that there are approximately 300 deaths from cancer *daily* in the United States alone. Such cases are scattered all over the world. It would be a physical impossibility for one man to care for even a minute fraction

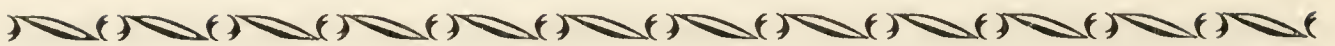
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of these sufferers and, if any doctor or any layman had a cure and would withhold such a remedy from these tortured victims by keeping it secret for his own personal gain, then a new and ultra-sublimated Hell should be specially created for such as he.

Today I got a letter from my brother James. Since I am at present vacationing in Florida, exact records are not available but, some 25 years ago, he had a cancer of the lower jaw and was operated on five times in rapid succession. Half of his lower jaw, one of his carotid arteries and one jugular vein are missing but he is in his eighty-fourth year and in excellent health today.

A few days ago a man drove many miles to see me and to tell me that his mother had recently died from natural causes at an advanced age. We have only one mother apiece and he was grateful. Thirty-seven years ago, in a little log house, I had operated on his mother, removed the big pectoral muscles, cleared out the axillary lymphatics and removed the breast *en masse* for a large cancerous growth and there had been no recurrence.

In the half-light of our present knowledge we are not doing so badly and I have full confidence that, with more light, we will eventually overcome this grim and grisly destroyer which we all fear.

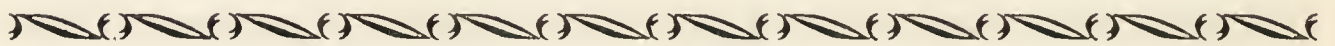


LXXII

SKIN CANCERS

“To do justly, to love mercy, to walk humbly.”

MICAH



AT THE time I am typing this chapter, it is just fifty-seven years since I began the study of pharmacy, and saw, for the first time, skin cancers removed by the arsenical and zinc chloride pastes. It is very nearly fifty years since I started the practice of medicine and began, in a limited way, to remove cancers by such means and by operative procedures, after leaving the hospital and entering private practice. More than a half-century of experience along this line, if coupled with close observation and a deep interest, should give one perspective, and if one is free from bias, should enable him to draw some conclusions. In November, 1910, over twenty-five years ago, I published an article in one of the medical journals giving a review of a series of 127 cases of skin cancers treated by me with Marsden's paste. Since that time I have treated many hundreds of cases. I mention this lest some of my critics assume that my deductions are without adequate foundation and formulated with undue haste.

Lest I be accused of bias, I may say that, as an interne on the surgical staff of Bellevue Hospital, I had ample opportunity to see the purely surgical and operative side of this question. I have excised a great many malignant growths and I have had, I believe, my full share of complete and permanent recoveries. A number of women, from whom I removed the breast, pectoral muscles and axillary tissues, from twenty-five to thirty-five years ago, are still living and in good health. I have used the roentgen ray on a number of my cancer cases and I have sent others to various institutions for X-ray or

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radium treatment. I have seen excellent results from all these measures and a due proportion of failures. I do not believe I am prejudiced. I know that I will come in for some sharp criticism for writing this chapter, but if it is nothing worse than adverse criticism, I will be content.

Cancer is a horrible thing. I shall continue to use any method of treatment which I think is wisest and best for the case in hand, regardless of current fashions in medicine. I cannot do otherwise until we have a real cure.

Early in my medical career, a man came to me with the history of an epithelioma over the mastoid. It had been excised nine months previously by a skilful surgeon in one of our large hospitals. Pathological examination had confirmed the diagnosis. It had recurred. I operated upon him three times, removing on the last occasion a chain of infected lymphatics. It again recurred. There was nothing left in the mastoid region but the mastoid, much scar tissue and the neoplasm. I applied Marsden's paste. A portion of the mastoid bone separated; he became deaf in that ear, but he lived some ten years after that without recurrence, dying of chronic nephritis.

I had several cases of senile keratosis of the back of the hand which had developed malignancy. Senile atrophy of the skin, together with a probable involvement in each case of the extensor tendons, made me hesitate. A radical operation meant an extensive dissection and crippling or an amputation at the wrist. I used the paste with entirely satisfactory results. On the day following its application, there were visible pinkish lines running up the forearm, a lymphangitis. There was food for thought here. I recalled that in the mastoid case not only a portion of the underlying bone sloughed out but a distinct prolongation in the line of the lymphatics. It seemed clear that the lymphangitis was due to absorption of arsenic. I had talked with many physicians who had used cancer pastes or plasters. I had read all the literature relating thereto which was available. No mention

had been made of the action of these agents on the lymphatic supply of the region involved.

I reasoned that in syphilis, we had the primary sore, then involvement of the inguinal glands and the secondary lesions, finally tertiary degenerations, spinal cord lesions, etc. I of course realized that in cancer we had first the primary neoplasm; involvement of the lymphatics came next, later, metastases and perhaps general carcinomatosis. Involvement of the lymphatic vessels and glands occurs in a greater or less degree in most local infections. Each portion of the anatomy has its own nerve supply, its own nutrient vessels, its own chain of lymph drains or sewage disposal plants, the lymph glands, a sewage system to get rid of waste products.

Is cancer due to an infection? Who knows? We have not yet arrived.

Sewers do not discriminate between April showers and bathroom waste. Our lymphatics will carry infective material, likewise the cancer poison, whatever that may prove to be, also arsenic. We know that the cancer cell, the cancer germ, the cancer virus, be it what it may, is prone to follow the line of lymphatics. In a measure we understand where these lymph vessels run, where the glands are located, but our knowledge is imperfect. There are untold numbers of them, placed systematically where they are needed, not by any hit or miss system. Surgically they are exceedingly difficult to follow. The knife does not discriminate closely and "the man behind the gun" is usually unable to do so with any great degree of assurance. The surgeon goes wide of the neoplasm, removes some of the definitely known glands; to make matters doubly sure, he dissects *en masse* certain areas of connective tissue known to contain lymphatics, as in the neck, the axilla, the groin. He is never quite certain he has removed them all. Not infrequently he must leave possibly infected areas, owing to the risk or because they are surgically inaccessible.

In skin cancers one may apply the paste and note the

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results. The lesions are superficial. He can see the neoplasm turn purple or black; a zone of tissue immediately surrounding the cancerous mass and presumably infected, becoming likewise necrotic, an additional outlying zone, possibly containing an occasional cancer cell, showing edema and inflammation, prolongations running with seeming irregularity in apparently sound tissue. He can see the lymphatic vessels inflame and the glands enlarge and possibly slough. Outlying cancerous cells are being destroyed by the arsenic, as it is absorbed, in areas perhaps unexpected.

The old writers stressed the "selective" action of these pastes. To me, it does not seem selective, mysterious, unexplainable. It resolves itself into a simple mechanical problem akin to testing a defective drain by means of an aniline dye or by substances with a strong odor like oil of peppermint. The cancer cell, being a degenerated cell, is susceptible to destruction by various agents to which normal cells are resistant and the arsenic follows the lymphatic drains in a manner which we are, as yet, unable to follow with the scalpel, hence the comparative immunity from secondary involvements, which seems so striking, when such growths have been removed by the cancer plaster. I have fortunately been so situated that I have been able, as a rule, to follow up my cases, year after year, to their ultimate conclusion. On this point at least, I know whereof I speak. Recurrences, secondary glandular involvements and metastases have been conspicuous by their absence.

Skin cancers are treated in various ways with far greater success than other malignant growths; we get them reasonably early, as a rule; no vital structures are involved; they are accessible; large areas of integument may be removed safely; as a rule, also, they make rather slow progress until the deeper tissues become seriously involved. A large majority of them are of the basal-celled type, affecting the face, and these are more amenable to any form of treatment than other types. These and other reasons account for the large measure of

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success which attends the treatment of skin cancers under widely divergent methods. My own records show less than two percent of failures which will, I believe, compare favorably with the results obtained by any other method as yet known. In the *New York State Health News* of February 1, 1932, is a brief review of some 340 cases of basal-celled epitheliomata treated at the State Institute for the Study of Malignant Diseases at Buffalo, New York. It is of exceeding interest. For years I have been sending in specimens for pathological diagnosis and have frequently visited this Institute. Hampered by lack of space, inadequate equipment, insufficient funds, they have been doing some remarkable and astonishingly successful work.

We all have failures. Skin cancers are largely confined to those of advanced age, wherefore sudden deaths are liable to occur from causes unconnected with the treatment. In our anxiety to help some of these unfortunates, we occasionally undertake, against our better judgment, hopeless or seemingly hopeless cases. The man who can show 100 percent of cures has either had more regard for a perfect record than for his patients, or he has indulged in the gentle art of embroidery. Some failures are due to faulty or incomplete diagnosis.

To illustrate, in one case many years ago, I excised a large cancerous gland situated in front of the ear, together with the parotid gland which was involved. Months later there was a recurrence which I removed with the paste and which never returned but my attention was turned to a bone expansion in the region of the antrum of Highmore. The X-ray, then a new aid to diagnosis, showed an extensive involvement of the antrum, which proved to be carcinomatous. I sent her to Montreal for operation. Complete excision of the superior maxilla failed. Reviewing the history of the case in all its aspects, I was forced to the conclusion that I had twice removed a purely secondary involvement without recognizing the

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primary lesion which had developed without definite symptoms. Following this, I bought an X-ray machine.

Deep-seated cancers are obviously not suitable cases for this treatment. The same is true as a rule in skin cancers which involve the mucous membrane to any great extent. In cancer of the edge of the eyelid, radium is advisable. I have no desire to attack other methods of treatment. They all have their uses. I use Marsden's paste. Other agents of this type may be good; some of them may be better, but I have had an extensive experience with this; I know how it acts and understand its limitations; it fits my hand. So far as I can judge, the roentgen ray can ordinarily do nothing in *skin* cancers which cannot be accomplished as readily and as safely by the paste when properly used.

So long as these neoplasms are without capsule, sending projections into apparently normal tissue, so long as it is practically impossible to follow with the eye and the scalpel the exact track of the lymphatic involvement, so long as human judgment is fallible, just so long will we have too many recurrences under purely surgical measures. We must go wide of the lesion, must sacrifice sound tissue as well as diseased, since there is as yet no definite means of determining the exact limit of the growth. Experiments are now under way which will eventually develop, in all probability, some staining method that will render these lymphatics distinctly visible. At present, the scalpel goes where it is sent, the Bard-Parker blade has no eyes, and man is prone to error as the sparks fly upward. Much mutilation is inevitable, at times, under operative procedure. From a cosmetic standpoint, the paste will bear comparison, the resultant scars being insignificant.

The paste I use is composed of equal parts of finely triturated arsenious acid and powdered acacia. This is mixed with water or, if the lesion is small, with a four percent solution of cocaine, to the consistency of soft putty. The neoplasm is covered with this to the extent of from three to four

millimetres beyond its apparent limit. While still moist, I am accustomed to pat into the paste a thin film of absorbent cotton and, a few minutes later, to apply over all a coating of acetone-collodion. If the lesion is raw and ulcerated, the arsenic, in an impalpable powder, is rubbed well into the oozing surface, the acacia being omitted, the protective covering and the after-treatment being otherwise identical. If the skin is unbroken, the cuticular layer is first destroyed by pure carbolic acid or caustic potash. If the superficial layer is elevated, dry and horn-like, it is scarified with a needle or scraped down with a scalpel.

Most writers following this line of procedure advise removal of the paste in twelve to twenty-four hours. I believe this to be a mistake and a potent cause of failure. I find that the average duration of the application in my own cases is three days. I never hesitate to leave it on much longer, should occasion require. Cancer is not to be trifled with and it is better to do too much than too little. No fixed rule can be laid down as to time of removal. If the growth is melanotic, the paste should cover a wider area and be left on longer than in basal-celled epitheliomata, but when this is done, the results are highly satisfactory. In any case the paste should be left on until the lesion turns a purplish black in color and there is a marked inflammatory edema surrounding it, at which time the advisability of its removal requires consideration. As with radiation, this is a matter of judgment in the individual case, guided by the location of the growth, its character and, above all, by those bumps of wisdom engendered by the hard knocks of experience. I have never seen sound tissues seriously damaged by prolonged application. The average radiologist can hardly say quite this.

Generally speaking, the slough requires no treatment. Due to the embalming action of the arsenic, the eschar dries down into a hard black mass which, ordinarily, should be left to separate of its own accord. In aged people with a sluggish circulation, I sometimes use a stimulating ointment of

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balsam of Peru. I do not hesitate to clip away a large and unsightly slough. Ordinarily the ulcer left, after the slough separates or is removed, heals rapidly. In my experience, there need be no fear of any serious arsenical absorption if the lesion is not over *an inch* or so in diameter. In very large growths, the possibility of its occurrence should be borne in mind but these large lesions are unlikely to be successfully treated by any method. I have yet to see a secondary hemorrhage and do not expect to, since the vessels become thrombosed and obliterated. I cannot place too much emphasis on the rule that *this line of treatment is applicable only to skin cancers* and that it should never be employed in lesions involving the mucous membrane or in extensive and deep-seated growths like cancer of the breast.

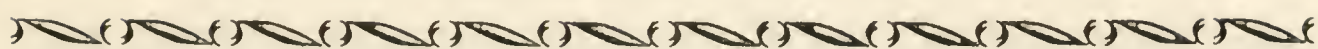
For too many years this line of treatment has been largely in the hands of the ignorant and unqualified. The eminent surgeon frowns upon it as unethical, unorthodox and altogether undesirable. Those of us who have had the temerity to put ourselves on record in its advocacy, are dubbed impostors, quacks, and charlatans. Hard names never settle moot questions. We should not be too severe in our condemnation of others who differ with us. The ultimate goal, which we are all earnestly seeking, is the same — a cure for these cancerous affections — but the fog is heavy and the routes still largely uncharted. The treatment by cancer pastes and similar procedures is being used by many physicians and by certain cancer institutes. Many of these use secret formulas, they advertise in an unethical way, they lay preposterous claims and deserve condemnation. Such birds are birds of prey — the vultures that hover over the dying.

On the other hand, I happen to know that some of the physicians employing such methods, are men of scientific attainments, of unquestioned integrity and that they are actuated by the noblest of motives. They have the utmost faith in the efficiency of their treatments and just reason to be proud of their results. Until that longed-for day arrives when

we have such a cure for malignancy as we have in diphtheria antitoxin, which relegated all other "cures" to the limbo of obscurity, the profession is not in a position to call us all down as impostors and mountebanks.

The use of the paste requires good judgment, properly selected cases and, like any other treatment, a reasonable amount of experience. It is not excessively painful. The country surgeon can gain experience by limiting its application to those cases which are small and superficial, like the patches of senile keratosis showing signs of malignancy and, as he becomes familiar with the technic or develops a better one, he will acquire confidence and skill. For the poverty-stricken, those in feeble health, or those who are unable to go to the hospital for other reasons, it is of the greatest service. If we admit — which we are prepared to do — that the standard of treatment in skin cancers has been raised by radiation, it must also be admitted that the cost has been raised, and "raising" the price is often a most serious problem, particularly in these days of financial depression.

As for that ghoul who advertises that he can cure cancer by a secret method, he should be translated, downward, to save mortuary expenses.

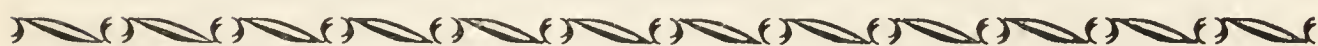


LXXIII

SKIN DISEASES

“He had a brass nose and one day, I swan,
It fell in his lap but he soldered it on.
He puttied the crack. He painted it black.
But alas and alack!
He had turned it around with the upper end down,
For he wasn't a tinsmith and hadn't the knack.”

S. Q. LAPIUS



DESPITE the vociferations of a group of noisy dermatologists, arsenic, internally, is one of our useful remedies in many skin affections, particularly those of a chronic and scaly nature. Those who condemn it are chiefly those who have never learned to use it intelligently or those skin specialists whose knowledge is merely skin deep and who consequently pin all their faith, presumably with a safety-pin, on purely local treatment.

Arsenic is a poison but it is one of the safest poisons that we use in medicine, due to the wide “spread” between the medicinal and the poisonous dose, giving warning long before the danger point is reached. This is not so with many remedies, of which strychnia is an example. In infantile eczema and scald-head of babies, it is practically a specific. Here I give it usually in the form of Donovan's solution with elixir of lactated pepsin or some similar vehicle. Such children bear it well in rather large doses, often up to six minims or more, beginning with a small dose and slowly increasing to the limit of tolerance. I have given it to adults, in some cases, in doses of from 30 to 40 drops without any manifestation of intolerance. I do not advise this to anyone not fully familiar with the evil effects of it in overdosage.

Years ago before intravenous ampoules of arsenical prepara-

tions were easily available, I treated a number of cases of generalized eczema of obstinate type by daily intravenous injections of Donovan's solution with very satisfactory results. I do not know if others have tried this.

The chronic and scaly forms of eczema are usually amenable to arsenic unassisted by any local treatment; the same is true where the auditory canal is itchy, dry and scaly, giving rise to head noises and other disturbances. Many of these cases are of an eczematous nature. As elsewhere stated, there are certain cases of eczema, associated with or alternating with, asthma and gastric derangements, which latter are accompanied by a dry prickling and hot sensation in the mouth and throat. Such cases often respond to arsenic, which not only abates the eczema but the other troubles as well. Here we are reminded of the Odd-Fellows emblem, three distinct links, separate in a way but inter-connected and inter-locked.

Those who fail to distinguish between the various forms of dermatitis and the eczema to which I have reference, will have numerous failures in the treatment of these common skin affections. When one has learned to search for the numerous agents which can *excite* a dermatitis, to take into consideration the habits, occupation and environment of the case in hand, to recognize the evidences of systemic disturbances and to find the dietetic errors which often cause these eruptions, the diagnosis and treatment of these conditions becomes infinitely easier. The controversy between those who believe in the purely local origin of eczema and those who maintain the opposite view, can only end in a draw, for both are, in a measure, indubitably right. The question should not be complicated by the narrow views and the jealousies of small minds.

Pompholix, a peculiar eruption of small blisters, appearing suddenly on the hands or feet, as a rule, and accompanied by burning and stinging pain, has been attributed by our dermatologists to stoppage of the sweat-glands, to ringworm infec-

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tion and to various other causes. Any internist who has ever suffered from it will concede that it may be due to a nerve lesion and is to be classified with the other herpetic eruptions such as zoster and ordinary herpes or cold sore.

Many cases of skin disease are in need of the services of an internist rather than a dermatologist. A good dermatologist should be a good internist as well. While many skin diseases are due to local irritation and infections or to other causes which affect the skin alone, it would be absurd to claim that drug eruptions, hives, zoster, the pigmentation of Addison, the toxic erythemas and a host of other eruptions, due to disturbed metabolism, are wholly amenable to surface treatment. Many have a combination of external and internal causes working in conjunction. We know that there is some connection between the diseases above mentioned, viz. eczema, asthma and the gastric disturbance. We also know that blackberries are red when they are green, but we are in no position to explain just why, any more than we can explain the marked tendency to atheromatous cysts, which we know is frequently found in the various members of some families. We do not know. As we remarked in the chapter on the Doctor in Court, it is the man who is afraid to say that he does not know, who finds himself in an untenable position. It is the extremist who exposes himself to attack and it is the extremist who, aside from his perfectly human proneness to err, exhibits another very human trait: he yelps if he is hard hit.

Many parasitic skin diseases are curable by the sulphur compounds. The old doctor who said that there was one class of skin diseases that arsenic would cure, one that sulphur would cure, and one that the devil himself couldn't cure, had at least a fairly workable hypothesis. Many years ago I obtained what seemed to me very excellent results in boils, abscesses, cutaneous erysipelas and various suppurative or parastic skin affections, by means of calcium sulphide. This had been popularized by Ringer, who advocated its use in

doses of 1 / 10 grain in pill form. It seemed to me at the time that a remedy made from sulphur and lime should not prove injurious in a much larger dose. I "tried it on the dog," as it were, by taking it myself and finally reached a maximum of 60 grains per diem, this with no ill effects whatever save an occasional eructation of gas flavored with sulphuretted hydrogen. I quit my experiment, not because I had reason to believe I had reached the limit of tolerance, but because I ran out of pills. The only trouble I ever had with this remedy is that many of these pills are inert. If one of them is dissolved in the mouth, the "stale egg" flavor is exceedingly distinct if the pill is of proper quality.

Practically all the sulphur compounds used in parasitic skin diseases have this odor to a degree. That of ichthyol is rather different but this is because it is not wholly a sulphur compound.

In scabies I use an ointment of precipitated sulphur containing a small amount of balsam of Peru. The precipitated sulphur makes a much smoother ointment than the sublimed sulphur commonly used. The patient is given a good scrubbing with green soap once a day, after which the ointment is well rubbed in.

As a rule, in order to effect a cure in a given case, every member of the patient's immediate family must receive treatment, and if the family is a large one, the attendant expense may be quite an item. Where this is the case, it is better to use diluted Vlemingcx's solution. This may be extemporaneously prepared, "home brewed" so to speak, at a merely nominal expense for the raw materials. It is practically a solution of calcium sulphide. It is in universal use among agriculturalists as a spray in parasitic diseases and infestations of plants of various kinds.

Used in scabies, it has the merit of destroying the parasite with far greater rapidity than most other sulphur compounds; the sulphur odor is stronger but much more evanescent than that of the ointments of sulphur and it has the advantage of

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not having that of greasy rancidity added thereto. As with other sulphur compounds, skin irritations may occur where the skin is unduly sensitive to sulphur. When this occurs, some patients think that the scabies is worse and use the preparation with still greater vigor, thus adding to their troubles. In sulphur irritation, the itching of the scabies is replaced by a smarting and burning sensation and, in the case of Vlemingx's solution, a chapped condition of the skin. In this case, the preparation should be diluted or omitted for the time and sedative lotions or ointments substituted. Used intelligently and properly, the results are very satisfactory, but the giving of complete instruction to the patient involves so much time and trouble that I have a printed circular which I hand out to my patients. This circular covers all the details of treatment and relieves me of a wearisome task. I instruct my patient to read it all carefully several times, not only the part telling them how to prepare the solution but the instructions as to its use. If I simply tell them, I am apt to forget some essential point or they (even more often) fail to remember.

This same preparation works effectively in the troublesome and deep-seated cases of trichophytosis where the hair follicles are involved. Ordinary ringworm is readily controlled and cured by many of the parasitocides. A single application of formaldehyde, well rubbed in with a swab, is frequently all that is required. Another good remedy is pyrogalllic acid, fifteen grains to an ounce of collodion. In athlete's foot, another form of ringworm, I have found that dusting the feet twice a week with equals parts of Thiersch powder and talcum powder is effective in preventing the disease. Many parasitocides will cure ordinary cases, the remainder yielding to roentgen therapy.

Senile pruritus is frequently a most obstinate and rebellious affection. As a local sedative, a calamine lotion containing about 2 percent of carbolic acid has given me more satisfaction than any other agent. In severe and intractable cases, full

doses of lithium carbonate or large doses of sodium bicarbonate have occasionally afforded relief. Other cases yielded readily to sodium salicylate. The cause is not infrequently diabetes or chronic nephritis. To say that it is due to degenerative changes attending senility, is merely stating that we do not know and that we are unwilling to admit our ignorance.

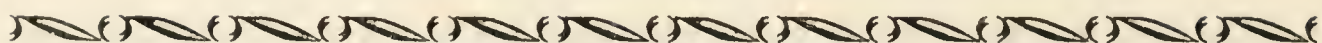
Warts quite commonly disappear spontaneously without any treatment. I have watched them grow smaller and flatter, from week to week, until they vanished entirely. Such occurrences explain the supposed efficacy of the many infallible "charms" in which many people still have the utmost faith. While it is our unquestioned duty to remove, in so far as we may, these motes of ignorance from the eyes of our lay brothers, we should not assume too lofty an air in so doing until such time as we have freed ourselves from the many beams which still blur and distort the eye of our profession. Warts frequently respond to treatment by repeated applications of monochloroacetic acid but its use requires supervision on the part of the doctor. A saturated solution of chronic acid is a much slower remedy but far safer to leave with the patient. A strong ointment of salicylic acid, rubbed in once a day, is likewise safe and satisfactory. Where there are but few warts and these of large size, the quickest and surest method is to excise them under local anaesthesia. Repeated rubbings with castor oil will cure quite a large proportion of these cases.

Venereal warts are of a very different type and they will, as a rule, disappear promptly if the parts are kept dry and a simple drying and disinfecting powder is used. There are many such in the market but I have had as satisfactory results from a mixture of calomel and boric acid as from any of the others. Treatment of the *cause*, by local douches, by internal treatment, or by intravenous medication as indicated, is of course an essential part of the treatment in order to prevent recurrences, if for no other reason. Tattoo marks may be removed by applying a strong solution of salicylic acid in

collodion. It may have to be repeated a number of times unless the marks are quite superficial.

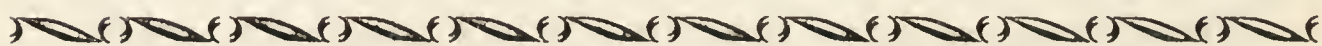
Gunpowder stains usually yield to the application of a 100 percent solution of ammonium iodide which turns them red. The red stain is subsequently bleached out with dilute hydrochloric acid.

These random suggestions might be expanded indefinitely but I refrain. It requires excellent judgment to know just what to remember and exactly how much to forget in the treatment of skin diseases. One thing to be always remembered is that very many atypical cases may be allergic in their nature. The nomenclature varies with the different authors and is not built on a scientific basis. John Elliotson in his *Practice of Medicine* written about 100 years ago, in describing lepra vulgaris, lepra alphoides, lepra nigricans, etc. says in his dry manner, "It is a great mercy that we have no other names given to intermediate shades."



LXXIV

BOILS AND CARBUNCLES



IN BOILS and carbuncles, after trying out very many lines of treatment, I have finally settled down to giving potassium iodide or the syrup of the iodide of iron in preference to any other treatment, aside from local and surgical methods. Where the subject is a victim of successive crops of boils, as is so commonly the case, it seems uniformly successful in cleaning them up and this, in many cases, where autogenous or other serums and vaccines have failed. Such cases of general furunculosis are sometimes quite distressing. I once had a man in the hospital who had more boils than Job unless the latter was an over-size man and had a bigger surface area. He had boils all over him except on the mucous membranes and the palms and the soles. My assistant counted them one day and they tallied 411 on that occasion.

A boil invariably starts at the root of a hair and as every dog has his flea, every boil has its hair coming from its center. They are never found on the hairless parts though some may be provided with only lanugo hairs. So-called blind boils are usually dermic abscesses and not true furuncles. Occasionally, boils are due to direct infection of the individual hair root and sheath, as in the boils which taxidermists sometimes develop on the back of the hand from dissecting animals or birds which have undergone some degree of putrefaction, or in the secondary boils which develop in the immediate vicinity of a discharging furuncle. Commonly boils come in successive crops and here we have some systematic dyscrasia combined with infection, usually by the staphylococcus aureus. Focal infection is a common cause.

In certain locations, a boil may not only be exceedingly

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painful but be accompanied by distinct constitutional disturbances. It is a common saying that every boil is worth a dollar to its possessor, which is not only an untruth, but were it true, would be a sound argument against the love of money. Some writers state that boils may begin either in a hair follicle or in a sebaceous gland. A boil beginning in the latter is not a true boil but an overgrown acne pustule which may resemble a boil.

But boils are healthy, if we are to believe what we hear. To be unable to sit down on the usual place may be healthy, but most of us would prefer to acquire health in some less unpleasant manner.

If it be deemed best to poultice a boil, I prefer a carbolized poultice made by stirring into a pint of linseed meal poultice while cooking it, a dram of carbolic acid. Such a poultice never sours, discourages the formation of small secondary boils by sterilizing the skin and has a marked anaesthetic action. Such portions as are not immediately used can be simply rewarmed as occasion demands. It should not be used on the fingers or toes on account of the possible though remote danger of carbolic gangrene.

A boil on the finger or on the chin or nose is infinitely more painful than in most other situations, due to the tightness of the skin and excessive tension resulting therefrom, all of which causes greater absorption of toxins with a corresponding increase in systemic disturbance. Thus it will be found invariably that when a patient has a boil on his finger and one on his arm, he will complain bitterly of the one on his finger though the one on his arm may be much larger.

Relief should be given by incision or excision which, if successfully performed, will always abort a boil. I say successfully advisedly, for the opening of a boil is one of the fine arts. I am frequently asked when a boil "is ripe and ready to be lanced." The answer is, "Just as soon as you have a boil." A boil is always ready for incision from the time it starts as a minute pimple-like inflammatory process involving the

hair follicle. The earlier this incision is made the better, since it invariably stops any further extension of the process. If done early, the incision is minute and trivial, there is little or no scarring and much suffering is avoided. A few drops of cocaine or novocaine solution should be injected along the line of the shaft of the affected hair follicle. Here it is frequently necessary to use a jeweler's loupe or other magnifier in order to ascertain the exact angle and direction at which the hair emerges. An incision is then made along the axis of the hair and if the sheath is properly opened, pus will be evacuated. If the boil had just started, the pus will be about the size of a pinhead, but the relief afforded is certain.

It is wise to bear in mind that, regardless of its size, a boil is invariably confined to the skin, which, however, may be very much swollen and thickened, particularly in the back of the neck where the skin is normally much thicker than in other locations. It is never necessary to cut through the entire thickness of the skin and there is consequently no danger of cutting any blood-vessels or nerves save those filamentary ones found in the skin itself. When the skin is not incised throughout its entire depth, the wound does not gape and the resulting cicatrix is insignificant. It is to be borne in mind in furunculosis that diabetes may be present and a urinary examination or, if available, a blood test for sugar is indicated.

A carbuncle is always a serious affection. It is readily distinguished from a boil if we simply recall that in a boil only one follicle is invaded while a carbuncle has multiple heads. Complete excision of a carbuncle, or incision and curetting under ether anaesthesia or other method of avoiding pain, is about the only method of treatment yet devised that has proved satisfactory. Here a sharp spoon curette comes into play. Freezing with ethyl chloride, save in the case of small carbuncles, is usually insufficient to enable one to do good work. Regardless of the size of the carbuncle, and they are often of immense size, there is no danger of hemorrhage if the operation is properly performed. In these cases particular-

ly, the relative amount of blood sugar should be ascertained if possible, and in any event the urine should be examined.

I had a patient with a very large carbuncle on the back of the neck, a farmer during the World War. This I excised, and one Sunday afternoon I went to his place to dress the wound which was then granulating nicely. On taking my departure, I said to him, "Mr. Roe, it will not be necessary for me to come again. I have left you a supply of dressings and enough medicine to last you for a time and have showed your wife what I want done. This will save me twenty miles of driving and you some money every time it is dressed. Keep up your medicine and you will have no further trouble."

He said, "I suppose my blood *must* be pretty bad. My neighbor, Mrs. Sherwood, told me that if I had only taken a teaspoonful of gunpowder when I first began to have these boils and carbuncles, I would never have had another boil."

Half a dozen of my patient's farmer-friends were sitting about the room, Sunday afternoon fashion, and a glance at their faces told me that a scientific rebuttal of Mrs. Sherwood's theory would be a waste of time, so I simply said, "Mrs. Sherwood is a very capable woman and I think she is fine. I fear, however, that she is not strictly up to date in her methods. What you should have taken, when your boils first started, was a dessert-spoonful of this new explosive, TNT, and a dynamite cap, masticating them thoroughly, and you would never have had *any* troubles of *any* kind any more."

After a minute, his face wrinkled in a slow grin; he whacked his knee with a horny palm and said, "I guess, Doctor, you've hit it about right."

Calcium sulphide, when obtainable of good quality, appears to be of much benefit in the furunculosis of diabetic subjects. I have seen the boils all clear up promptly under its use and, at the same time, a heavily loaded urine become sugar-free, this with no material change in the regular diet. A few cases prove very little. I have an Esmarch bandage in my office now, in use from time to time. I bought this band-

age in 1888, from a pawnbroker and it was plainly one that had seen service at that time. It is still in excellent shape, smooth and elastic. It has had no care, has been boiled innumerable times and is free from cracks or checks. This does not prove that rubber is, as a rule, very durable.

Yeast has proven very serviceable in the treatment of furunculosis, if taken for some length of time. Of late, manganese has come into use but I have had insufficient opportunity to give it a thorough test. The same may be said of the tin salts which are now being advocated for boils and similar conditions.

I have learned to avoid the use of the word furuncle, in speaking of boils to my patients. I deeply offended one lady by saying, "A furuncle is a mean thing . . ." when she broke in angrily, "He isn't a mean thing. My uncle is a kind, decent, generous man."

Uncle Eph tells this one, which applies to the use of technical terms in ordinary conversation.

"Doc Jenkins was in this mornin' an' he says, 'Si Perkins' wife asked me how Miss Kent was comin' along. I told her she was in a bad way, that when I saw her last she was in bed with osteo-myelitis.

" 'Mrs. Perkins said, 'Think of her taking up with one of them nasty foreigners.'

"I asked Doc Jenkins, 'What's the joke?'

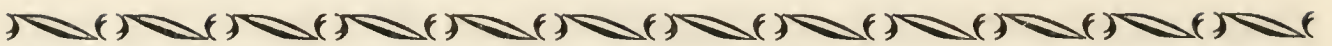
" 'Oh,' he says, 'explaining a joke is some like splitting a cat open to show her insides. You can *see*, all right, but it sort of *spoils the cat*.'

"The old Doc is a mighty nice old chap but he's queer, like that, sometimes."

One critic who read my manuscript said that some of the humor was too coarse. I plead guilty. It was not written for those who, as Senator Ingalls once remarked, "could walk on the keyboard of a piano without making a sound." It was primarily written for the plain and oft-times inelegant country practitioner who sometimes feels that humor can be

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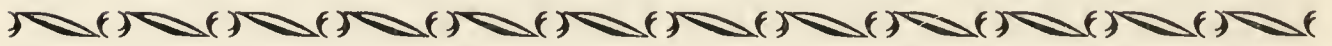
drawn so fine as to be absolutely impalpable. We meet with so much suffering and distress, so many illnesses and infirmities, so many trials and tribulations, so many conditions that are past all human aid, that we must assume a cheerfulness if we have it not; we must grin or go gaga. Personally, I am already so ancient that I can no longer shudder and feel martyred when anyone has the temerity to criticize me. Moreover, it is no part of my business to cure and sugarcure hams.



LXXV

GOITER

Relative to the Great American Goiter Belt



FIFTY-SEVEN years ago, to my personal knowledge, the iodides were in common use in the treatment of ordinary goiter. It was no new treatment at that time. The new developments lie along the line of etiology, and in the classifications of the various types, classifications which vary and are still in formative stage. There seems to be a general impression that the iodides are used chiefly in syphilis; that it is a reflection on the moral character of the patient to give him potassium iodide. Such an attitude is unfortunate as well as absurd since the iodides have little if any effect on the *spirocheta pallida*, and while useful in syphilis in resolving inflammatory exudates, gummata and the like, they are equally efficient in similar conditions and a large variety of disorders which have no connection with lues. In fact, they are almost indispensable in diseases like actinomycosis, goiter, and a great number of maladies which, so far as we know, are wholly unrelated to infections running "even to the third and fourth generations" and even to each other.

We hear a great deal these days about iodine starvation, and have at last come to realize that iodine should no longer be classed wholly as an alterative remedy, foreign to the system, but as a restorative and a food, supplying an essential, satisfying a deficiency. Those of us who have practiced extensively in the Great American Goiter Belt know that it is almost imperative to overcome the prevalent iodine starvation by the administration of iodine in some form. We read of late of the dangers of iodine medication in goiter cases. Such cases are classified and sub-divided. We are warned not

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to give iodine in toxic goiter and in this or that type of thyroid affection. Medical practice is constantly undergoing change, which is eminently desirable. The opinions of today will be tomorrow condemned. Current medical literature, the proceedings of our medical societies, our recent textbooks, all are constantly teaching us, if we but heed, that old theories are being revived, old methods of treatment being rediscovered and hailed as new and startling improvements. The science of medicine is in a constant state of flux; things that were at the bottom of the melting-pot for a time reappear at the top; some of those at the top sink into obscurity.

In the textbooks and in current literature, it is difficult to find any two authors who agree fully in their classifications of goiter. There are so many discordant notes, in the chorus against indiscriminate iodine medication, that all sense of harmony is lost. Meanwhile, the family doctor goes blithely on his way, using his own judgment (what little he has) until such time as the wheat is separated from the wind-blown chaff, or to change the metaphor, until the channel is officially buoyed. As it is, we are far from accepting all we read and hear. Facts are unalterable but opinions differ. They not only differ but they are subject to change. We, the G. P.'s, — and by this I mean the general practitioners, not the grateful patients or the general paretics — have the utmost respect for established facts.

The time-honored doctrine that iodine, in some form, was the best remedy for goiter, has been confirmed, and the necessity for its use admitted. Many of our institutions for the young, where endemic goiter is common, are feeding children iodine, usually in the form of iodized salt. In this connection, O. P. Kimball, in the *Journal of the American Medical Association*, made an interesting report on the prevention of goiter in the cities of Cleveland and Detroit. This report shows that, in 1924, the incidence of goiter in the public schools was 36 percent. In 1930-31, this percentage had dropped to 2.1 following the use of iodized salt.

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I began the study of pharmacy and medicine with Dr. Gillis, whose medical training was rather incomplete but who had rare judgment and an unusual amount of general information backed by horse sense. At that time, in common with most of his associates, he was using iodine and the iodides in goiter. No treatment, at that period, seemed better established or more successful in the goiters which were encountered. Since that date in 1880, I know of no patients within my riding, either in my own practice or in that of any of my immediate associates, upon whom goiter operations have been performed, save in the three instances noted below. This period represents forty-nine years of exceedingly active practice and fifty-six years of definite knowledge of what occurred in this one locality where I have always lived. I was treating one of the cases above referred to, a patient with a distinct exophthalmic goiter. During my absence in Florida, she went to Montreal, I believe, and was operated upon with satisfactory results.

Some thirty years ago we lost one case of severe exophthalmic. This patient had been under treatment by physicians in this and other towns. For a short time I had her under treatment.

The third case was puzzling and obscure. After a metabolism test was made, he was sent to the Lahey clinic in Boston and a low thyroid was removed in two stages with gratifying results.

We had another case of exophthalmic goiter which I treated in conjunction with two other local physicians. She was in a precarious condition and we sent her to Montreal to a hospital for operation. She was returned as inoperable on account of her bad general condition and enfeebled heart. She got well from her hyperthyroidism and the goiter disappeared. She died at an advanced age, about ten years later, from a fractured hip. This is our record. If iodine were such a dangerous remedy as we are still told by many, I am at a loss to account for these facts, when to my knowledge, iodine

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in some form was the standard remedy, used, I believe, in practically every case, either internally or externally, and very commonly in both ways.

Exophthalmic goiter is not of very frequent occurrence here. Hyperthyroidism we find occasionally. Simple goiter, with some disturbance of formation of thyroxin, and endemic goiter constitute the majority of our cases. If the administration of iodine tended to produce hyperthyroidism, why is that condition so comparatively rare in this locality? If it is an instance of what is known as "fool luck," the luck has certainly been unusually persistent, despite the chances we have taken in over half a century; this in a section where the ordinary types of goiter are exceedingly common.

Naturally I have seen many goiter operations in various hospitals and clinics. I have also had opportunities to examine many patients who have had goiter operations, at one time and another, operations that were successful and satisfactory. The operation for the removal of the thyroid has been perfected to a large degree and the beneficial results arising therefrom are indisputable. The goiter surgeon removes the major portion of the glandular overgrowth and with it, the tendency to the formation of an over-supply of those internal secretions which act as toxic agents. Proper metabolism is established. He leaves a portion of the gland untouched, so that it may continue to function but this likewise leaves the *cause* untouched. He removes the effect of some pre-existing cause, which doubtless still persists.

I question if the most enthusiastic of our goiter specialists would have the temerity to claim that, in removing the gland, he removed the basic causative factor. If so, "let him rise up and say it," a la Spartacus. He removes the cause of the toxemia resulting from goitrous overactivity, not the cause of the goiter. We are not trying to belittle his efforts or becloud the high point of efficiency he has attained, or minimize his skill and dexterity. We are merely trying to show that there remains much arduous climbing before the pin-

nacle is reached. We have been making rapid progress but we have only reached the heights where we have a fairly clear view of the vistas beyond. The study of hyper- and hypothyroidism is still in its adolescence. Meanwhile, let us remember that the use of iodine in goitrous conditions very nearly coincides with its discovery well over a century ago. The only reasonable explanation of the uniformly excellent results obtained in this locality from the use of iodine and the iodides in goiter as well as in other conditions to which attention has been called, appears to be this: that an iodine deficiency exists in this locality, a deficiency which manifests itself in various ways. The inference would be that this line of treatment should prove of great benefit in other sections where similar conditions prevail.

It is my sincere conviction that goiter is but one phase of iodine starvation and that many other disturbances will eventually be found due to this same underlying deficiency. I cannot emphasize this too strongly.

LXXVI

ECLAMPSIA

"My salad days, when I was young in judgment."

ANTHONY AND CLEOPATRA

IN THE treatment of puerperal eclampsia, our energies should be directed, of course, primarily toward its prevention. It is stated that it occurs most commonly in primiparae and in multiple pregnancy. This I can fully corroborate. In twin pregnancy, its frequency is undoubtedly due to the three-fold task of elimination thrown upon the kidneys as well as to the pressure which is, of course, a factor as in primiparae. When the reserve power of the kidneys is less than normal, or becomes seriously impaired, the liability to eclampsia is naturally increased.

Once eclampsia is imminent or has occurred, the chief aims should be to counteract the toxins already in the circulatory system, to promote elimination and to control the nervous phenomena. The chief premonitory symptoms are scanty urine, headache and gastric pain. Scantiness of urine is a better warning signal than the presence of albumin in the urine. While albumin is in nearly all cases present in quantity, it may not appear early enough to enable us to ward off eclampsia, but the eclamptic attack is usually preceded for some little time by scanty urine. By directing patients to measure the urine daily, sending in a specimen for analysis whenever the daily output is below normal requirements, or whenever there is headache or gastric pain, we are on much safer ground than if we merely make a routine examination of the urine at stated intervals. Of these three cardinal symptoms mentioned, any one or even two may be absent, but it is altogether unlikely that any eclamptic attack would occur in the absence of all three. There are, of course, other evidences of danger, but it will suffice to impress these three upon the patient since too much detail may lead

to confusion of mind. The others are here of lesser moment.

I have had ample opportunity to familiarize myself with eclampsia, having in my earlier days succeeded in saving a number of women who had been given up as hopeless by the attending physician, had received the last sacrament from the clergy, and been abandoned to their fate. A succession of such cases gave me a reputation in the treatment of this disease which, whether merited or not, led to my being called in frequently to cases outside of my usual riding limits. Many of these were late cases, were in profound coma when I first saw them, and frequently it was difficult or entirely impossible to get them to swallow anything.

In these desperate cases, two drops of croton oil under the tongue will usually produce copious watery stools within two hours, and while croton oil is too drastic a purgative for ordinary use, it has the advantage of acting as a purgative, even if not swallowed and curiously enough does not seem to irritate the buccal mucous membrane. It is dependable, seldom failing to purge within a reasonable time. Meanwhile, some reliable preparation of *tr. veratrum viride* is given half-hourly by the hypodermic method in sufficient dosage to bring the pulse down to 70 and keep it in that vicinity. I have a decided preference for the old Norwood tincture. The tincture now official is too weak for hypodermic use, and some of the special preparations intended for subcutaneous administration have in my hands failed to produce results. This strong tincture is irritant, and the injections are rather painful, but I have never had a resultant abscess, and since most of the patients were in imminent danger as well as unconscious, a little irritation seemed to me of minor importance.

Eclamptic patients are extremely tolerant of *veratrum viride*. Vomiting is an indication of value, and when this occurs, the remedy should be omitted temporarily as is also the case if the pulse falls much below 70. The remedy for both is to lower the head and give opium in some form. *Veratrum* reduces arterial tension rapidly, and the eclamptic pulse

is always a high tension pulse. It controls the convulsive tendency. No definite rule of dosage can be laid down. It takes about twenty minutes to secure the effect if given hypodermically and, having in mind that the eclamptic bears it well, the dose should be repeated every half-hour or so, until the effect of the drug is manifest, the dose varying with the potency of the preparation in use, the susceptibility of the patient to its effect and the urgency of the case. Veratrum, venesection, morphine and chloroform inhalations should control the convulsions for a sufficient length of time to enable one to secure free catharsis from the croton oil. Sulphate of magnesia, intravenously, may be of great service. It can be given every hour but should be injected in the vein very slowly. The usual dose is 20cc. of a 10 percent solution.

Once free purgation occurs, the worst of our troubles are over. If much acidosis is present, glucose may be of benefit. In my earlier years of practice, forced delivery was frequently resorted to but gradually abandoned save in exceptional cases, better results being obtained by a more conservative treatment. Veratrum has been my chief reliance. I have not given some of the more recent plans of treatment sufficient trial to enable me to pass upon their merits.

I have had a number of women who, in preceding pregnancies, had eclampsia during each labor, and quite often premature labor had been brought about in the endeavor to avoid convulsions. Eclampsia, occurring in the early months of pregnancy, is usually considered sufficient warrant for emptying the uterus. To many of us, the idea of taking a human life, even though it may be a foetus, is so repugnant that we adopt it only as a last resort. I have carried many of these women through to full term and apparently normal labor when, in the early months of pregnancy, they were either on the verge of convulsions or eclamptic attacks had already occurred. Limitation of food intake, a milk diet, plenty of water, occasional gastric lavage and colonic irrigation can accomplish much. I watch the excretions, test the

urine, keep a record of the blood pressure and keep them under moderate doses of veratrum. The condition is one of autotoxaemia, chiefly affecting the nervous system. A firm hand, a cool head and strict discipline can do much to insure safety to all concerned. I feel a warm glow when I meet certain estimable young men and women, knowing that they owe their lives, in a measure at least, to the care I gave their mothers.

I am strongly in favor of the conservative treatment of eclampsia believing that the mortality of both mothers and children is, on the whole, much less than when active measures to empty the uterus are instituted. Objection has often been made to veratrum as a dangerous drug. A scalpel is dangerous in the hands of a bungler but it is an instrument of precision in the hands of the skilled. Where it is possible, patients with threatened eclampsia should be hospitalized and a close watch kept on the diet, the urinary output and the blood pressure.

In a very large percentage of the cases I have encountered in country practice and on the Indian reservations, convulsions or coma was already present at my first visit. Eclampsia occurs most frequently with the first labor which is prone to be tedious: the relatives and friends are sure to be anxious and distracted: commonly the patient occupies the only bed or couch available: often there is no food save boiled potatoes and fried pork and, in the winter, the house is poorly heated. To spend one of our long, stormy Northern nights, sitting in a straight-backed kitchen chair, to carefully manage such a case single-handed and bring it through to a successful conclusion, requires courage, a steadfast determination to overcome not only physical but spiritual weariness. Such a bedside is no fit place for weaklings.

In the early days of my practice there was greater mortality from eclampsia than from difficult delivery or from infection. Owing to preventive measures, including education of the public, it is now of comparatively rare occurrence.

LXXVII

UTERINE DISPLACEMENTS

A few random suggestions, not wholly at random

UTERINE displacements are of frequent occurrence. Many of them, if not extreme, may be disregarded; others are productive of much trouble. We not infrequently find anteversions and retroversions in women who consider themselves in perfect health, suffering no inconvenience of any kind therefrom. When pregnancy occurs in a badly retroverted uterus, it may cause a lot of trouble until replaced and held in position by a proper pessary or other means of support. The knee-chest position is commonly necessary in order to dislodge and replace it under these circumstances, and the Smith and Hodge types of pessary have in these cases given the most satisfactory service so far as my personal experience goes. In the presence of dense adhesions, such cases are necessarily very troublesome, but much can be done with patience and appropriate measures.

Cases of prolapse of the uterus are not uncommon in which the patient is either unwilling or unfit for operation. In such cases, I have had, on the whole, the most satisfaction from a glass globe pessary of the proper size. There are various kinds of soft rubber pessaries which serve quite well in holding the uterus in position, but they have the defect of rapidly becoming offensive despite every care which may be given them.

In severe cases of procidentia, where operation for any valid reason is not advisable, absolute rest in bed for a time, followed by the use of a well-fitted supporter of the McIntosh type, has given a great deal of comfort to some of these sorely afflicted women. Many condemn these supports, and they

have definite drawbacks, but they are still of much service, in many cases, when properly adjusted. Many of my patients have had great help from them, and this is sufficient justification. Private Mulvana said, "Hit a man and help a woman and you can't be far wrong anyways." I do not vouch for a literal quotation, but the principle is first rate. One should not expect to fit one of these stem pessaries against a badly lacerated and ulcerated cervix and get any satisfaction.

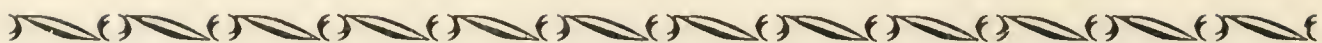
One trouble which often arises — befalls might be more appropriate — in prolapsus cases, is cystocele or falling of the bladder. In former years, when every woman wore from one to six heavy woolen or quilted petticoats, it was imperative that the weight of these be supported from the shoulders, if relief of the cystocele were to be sought from non-surgical procedures. In cases which for any good reason are inoperable, a proper support will give a large measure of relief. The average woman, free from pelvic congestions or inflammations, can carry a lot of urine in the bladder without discomfort, the bladder being more capacious than in the male. A quart of urine will weigh over two pounds, the exact weight naturally varying with its concentration. If a woman is on her feet much of the time, the dragging and joggling of this weight tends to the formations of a cystocele, if the pelvic floor is weakened from any cause, and will invariably aggravate one already existing.

She should be instructed and trained to empty her bladder at frequent intervals. In many cases there is residual urine and she should be taught how to get rid of this, at each urination, by pressure of the fingers, and to replace the bladder as well as possible. A glass globe or hard rubber globe pessary, if of proper size, gives much comfort to such patients. Boric acid dry tampons, *not* tampons of boroglyceride, to support the prolapsed organ or organs, serve a good purpose and the patient should be shown how to prepare these and place them properly. The residual urine frequently gives rise to a cystitis and a few bladder irrigations and other appro-

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priate remedies for such conditions are indicated. Properly performed surgical operations upon the pelvic supports constitute the only known cure for cystocele but the above recommendations have given much comfort to many of my patients, and some of these procedures, if carried out after operation, tend to prevent recurrence of the cystocele.

Order is said to be heaven's first law, and in some cases, the doctor's orders should be a close second. However, in advocating such purely palliative measures in this class of cases I must beg the clemency of the operative surgeon.

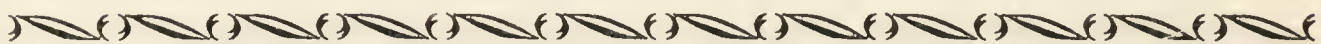


LXXVIII

CERVICAL LACERATIONS, LEUCORRHOEA

“But — cheap repairs for a cheap ’un — the doctors said I’d do.”

KIPLING’S *Rhyme of the Mary Gloster*



AS SUGGESTED in the chapter on Uterine Displacements, a woman who is not in fit condition to have an operation for prolapse is probably unfit to have a trachelorrhaphy, which is perfectly true. I have found in country practice many a woman with a lacerated cervix who, having a large family to look after and manifold duties to perform, would not permit me to operate although such operations are successfully performed in the patient’s own home. Unable or unwilling to go to bed for the necessary time, and dependable help in the way of servants being unobtainable, she would drag around as best she could as long as she could keep on her feet. Farmhouse help is hard to get, and far too often, mighty poor stuff when you get it.

Confronted with such conditions, I felt compelled to fall back upon an old method of treatment of cervical lacerations, a treatment which had, at any rate, the merit of being ambulatory. After repeated trials during the ensuing years, I gradually worked out a very practical method. I do not wish to be misunderstood in this. I much prefer to do a regular trachelorrhaphy, but I can get entirely satisfactory results by either method. One disadvantage is that the treatment requires several months to effect a cure but this, in the class of cases to which I have made reference, is more than offset by the fact that the patient is not required to go to bed after the treatment but can continue her customary routine of household duties.

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The treatment which I have worked out is as follows: — The patient is placed in the dorsal position, in a good light and the cervix well exposed with a bivalve speculum. The lacerations are spread for careful inspection by means of a tenaculum or two and mopped dry of all secretions. The cervical canal is usually full of glairy mucous and this should be removed by applicators wound with narrow strips of gauze. A small wick of gauze wet with dilute acetic acid, or with a solution of citric acid, is used to plug the cervical canal; other pledgets of gauze or absorbent cotton, similarly wet, are packed in the cul-de-sac of Douglas and on either side of the cervix. These are for the purpose of neutralizing any caustic which might otherwise exert its action where it is not needed.

The caustic which I find is best adapted for this purpose is what is known as Vienna paste, in the stick form. It is a mixture of caustic potash and quicklime. Caustic potash or caustic soda in the same form will serve but it is wiser to use the Vienna paste since this is not so deliquescent. The stick of caustic is held in a pair of dressing forceps of a type which will hold it firmly without crushing it and the forceps should have an automatic lock. The entire red, raw and granulated surface of the laceration is then rubbed with the stick of caustic until it is thoroughly blackened and softened, after which any excess of caustic is neutralized by one of the acid solutions referred to. The pledgets and the cervical plug are now removed, a dry tampon, provided with a string or tape for convenient removal, is packed well up against the cervix as an additional protection and the patient allowed to get up. She is directed to remove the tampon after the lapse of a few hours.

The patient suffers no actual pain of any moment during this treatment, merely a dull ache for a time, an aching sensation somewhat akin to menstrual pain. If of a nervous and sensitive make-up, she is apt to experience a slight faintness which passes off shortly. She is allowed to resume her custom-

ary vocations and avocations. Save for a daily lysol or similar douche, to promote the subsequent healing process, she requires no further treatment for six weeks or more. One of my early mistakes was in repeating the treatments too soon. Time should be given for the subsequent healing before a second application is advisable, otherwise you simply keep the raw surface from closing properly. The average case requires from two to three treatments to effect a cure.

I tried out a large number of caustic agents and find that the Vienna paste has proved itself much more satisfactory than any of the others. It penetrates to a sufficient depth, is less painful than many of the caustics; it is more manageable and it leaves a mucous surface more pliable and more normal in appearance than some caustics, a surface that heals readily after its use.

Nitrate of silver does not penetrate to a sufficient depth and its application is frequently followed by more or less hemorrhage. Churchill's tincture of iodine is ineffective. Some of the strong acids leave indolent ulceration in their wake. The electro-cautery is adapted for the treatment of small and well-defined raw areas left after the caustic, since its action can be definitely limited to the small unhealed points. It is not satisfactory for the treatment of large lacerated surfaces. The Vienna stick should be kept in a wide-mouthed vial with a little quicklime and the vial tightly stoppered to prevent deliquescence. It must not be touched with the fingers since it is an energetic caustic.

Stenosis of the cervical canal may easily result if the canal is not properly plugged by the method indicated. The vaginal mucosa must be protected, since burns of this sensitive tissue are apt to be quite painful and may be followed by scar tissue with adhesions. The final results are a *normal* appearing cervix, both as to mucous membrane and size, the swollen lower uterine segment slowly resuming its normal size as the raw surface gradually heals. A moderate linear depression occasionally remains to show the seat of the laceration. When

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it was the custom to pierce the ears for earrings, we not infrequently saw ears that had been torn and allowed to heal in bifid form. It was of no great moment save as a slight disfigurement. A similar cleft in the cervix should not be a matter of public interest and it is equally harmless.

It has been often stated that, in the operation of trachelorrhaphy, all scar tissue should be removed, otherwise reflex troubles will arise from pinching of the nerves in the cicatricial tissue. This is undoubtedly possible but it must be exceedingly rare, since I have never encountered it. The cervix has no large nerves. Compared with other genital tissues it seems, to a large degree, insensitive to pain. I have operated on a large number of lacerated cervixes, have treated a still larger number by the method above outlined; there appears to be very little dense scar tissue left after either method and I have been entirely satisfied with my results in either case. Carcinomatous degeneration is apt to follow an unhealed laceration of long standing. It also occurs, though less frequently, where there has been no laceration of the cervix. I have never seen cancer of the cervix following a trachelorrhaphy or the caustic treatment. I was merely lucky in this for I have seen many of these malignancies.

The treatment by the caustic requires as much skill and judgment as the operative method. The sole advantages which I see are that it avoids an anaesthetic, any confinement to bed and any danger to life so far as my experience goes. This method is chiefly applicable to those patients who cannot, or will not, submit to the regular operation. Its disadvantages are that there is less glory and smaller fees for the doctor. In either instance the functional results are practically identical.

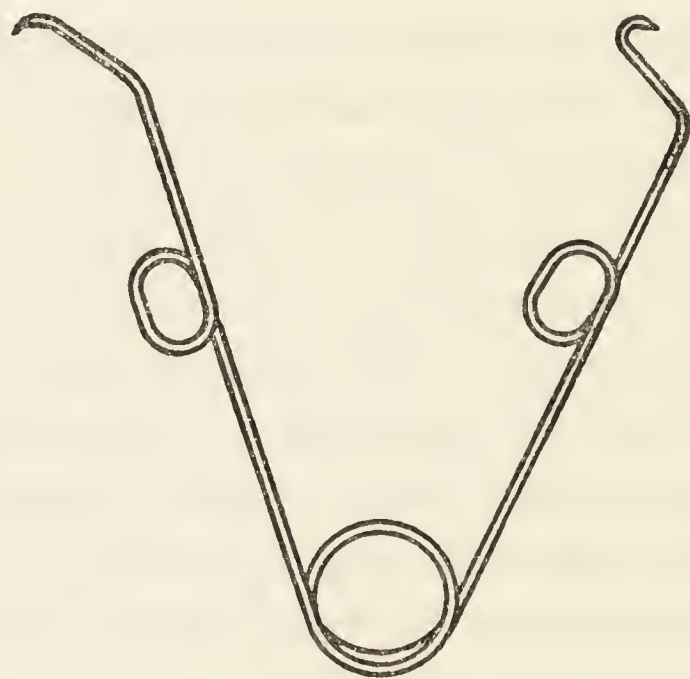
The treatment above outlined is for cervical lacerations as distinguished from cervical erosions, the latter being of minor import and yielding to less radical measures.

Occasionally we find a case of chancre of the cervix which may closely resemble an old ulcerated and lacerated condi-

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tion. We should always be on our guard for this as well as for that other dread condition, carcinoma, which may complicate a neglected laceration and, in consequence, be overlooked.

In country practice when, without assistance other than some domestic nurse or a neighboring farm-wife, it becomes necessary to do a perineorrhaphy, or under similar conditions in old lacerations of the perineum in need of repair, I have found the device (shown in the accompanying sketch) to be of the utmost service. It is readily made from a bicycle spoke in a few minutes with the aid of a pair of pliers and a file. The shape, spring tension, etc., can be varied as occasion requires from time to time during the operation, without tools of any kind. It takes up little space, does not impede vision, does not interfere with the necessary surgical maneuvers in preparing the surface or putting in the sutures, is self-retaining and has advantages over any similar instrument with which I am familiar. Others may have improvised a similar device, necessity being the mother of invention.



Dr. Jenkins frequently tells the story of the farmer who remonstrated with his wife, who was in labor, for making so much fuss about what was a perfectly natural process.

"John, I just hope you'll have one some day and that it'll be the shape of a rocking-chair," she snapped.

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Leucorrhoea, in one form or another, is one of the common ailments met with in women. Where it is chiefly a vaginitis, the flow is more or less constant and usually purulent in character, while that due to an endocervicitis is apt to be ropy or glairy; the discharge in endometritis varies in character but is prone to come in gushes. In vaginitis, a douche once or twice a day of a full teaspoonful of sulphate of zinc to each quart of hot, soft water, is not only effective but is quite inexpensive, which in some cases is a matter worthy of consideration, since it is usually necessary to use these douches steadily for a number of weeks in order to effect a cure. I find this zinc salt far more effective than most of the antiseptic washes in common use.

Failure to effect a cure by this means is usually due to the tendency of most patients, unless otherwise instructed, to use the douche in a sitting position either over a vessel or in the bathtub. Here the vaginal walls are in contact and, using any ordinary syringe, the douche simply runs back along the sides of the syringe tip, only a small part of the mucosa being reached. With the patient lying on her back, the vagina balloons out, and fills with the solution and overflows. Syringes with a large bulb and a vulvar shield which prevents escape of the solution, obviate this usually but have other drawbacks. The ordinary fountain syringe, in the dorsal position with the hips elevated if need be, is on the whole the most efficient. In the absence of proper equipment in the way of douche pan, it is a simple matter for the patient to lie across the bed, a flat cushion if need be under the hips and the vulvar outlet well over the edge of the bed; the feet should be placed on a chair and drainage provided for by a piece of waterproof nursery sheeting or similar material; this apron can be so pinned in front as to form a gutter so that the solution will drain into a slop-jar or similar receptacle on the floor. To be effective, the douche should be used for at least ten days after the leucorrhoea has disappeared.

There is one form of leucorrhoea, frequently but not al-

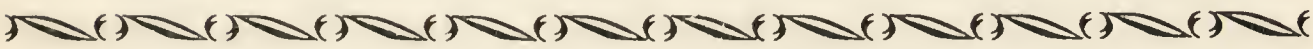
ways occurring in pregnant women, which is exceedingly distressing. The secretion is whitish, curdy in appearance, causing intense itching, an annoying pruritus. The discharge is so scanty that it is often unnoticed by the patient. The vaginal mucosa is congested and there are superficial erosions. The urinary organs may at times show evidences of irritation, but even if they do not, the urine should always be examined. If sugar is found, appropriate measures should be taken. In the absence of diabetes, proper douching usually affords prompt alleviation.

LXXIX

CURETTAGE

“Present fears are less than horrible imaginings.”

MACBETH



MANY cases of simple menorrhagia, and by this I mean the cases that are not due to uterine fibroids and polypi, to malignant disease, hypertrophic endometritis, retained secundines or similar organic causes, are relieved by potassium or sodium bromide. Such cases are probably due to some derangements of the nervous or the circulatory systems, to endocrine dysfunction, or to some abnormality in the blood. Excessive flowing at the menopause or any renewal of the flow after that period has been definitely passed, should arouse suspicion of malignancy. This is old stuff but so are the Ten Commandments, and such things bear repetition.

In a large proportion of menorrhagias or metrorrhagias, of excessive menstrual flow or cases of uterine hemorrhage, from any of the usual causes, the curette is a most efficient instrument. This is true even in the presence of fibroids. I have had quite a number of these cases where, owing to serious cardiac disease or other excellent reasons, operation was inadmissible, and the only course, prior to the discovery of the X-ray and radium, was the curette. During this period, I curetted several of these patients every two or three months, for many years, until the menopause relieved them of the necessity for this procedure. I recognize the possibility of the development of malignancy in such, but I was fortunate in that the fibroids atrophied with the rest of the uterus and became harmless, after the menopause. When operation is inadmissible we must do like the poor, unfortunate Hindu who does “the best he kin do.”

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The family doctor is repeatedly warned by our gynecologists, who doubtless deem it their duty to safeguard the immature mind, of the dangers of curettage and the risk of perforating the uterus. This is perfectly right, in a way. Given a softened uterine wall and a rough or heedless operator, such accidents do occur but the warning seems unduly stressed. I have never had a perforation and my Maker knows I have done a lot of curetting. Should such a thing ever happen, I would feel like the small boy who asked Santa Claus to bring him a jackknife that would cut sticks but not fingers. It seems to me to be a contingency to be guarded against but not unduly feared. I have done a large number of curettements under varied conditions, in the hospital, in my office, at the homes of my patients, usually without an assistant, and I have had no such accident.

Again, I never put these patients to bed simply on account of the curettement and in the absence of some other definite reason. I am accustomed to let them drive home, ten, twenty, or thirty miles, after having had this done and, so far, have had no occasion to regret this mode of procedure. It is true that I have come in for some sharp criticism on the part of those who considered it wholly unwise and unsafe, but they were unable to point out any case that was apparently injured thereby. We have had some very lively and interesting discussion on this point, at medical meetings and elsewhere.

Aside from a light hand and reasonable skill in handling the curette, together with a wholesome fear of the operation when there is acute infection of the uterine appendages, there are two essentials in the performance of this comparatively minor operation. One is good surgical drainage and I maintain stoutly that such drainage is a physical impossibility so long as the patient is confined to the recumbent posture. In so far as drainage goes, it is not a matter of opinion but of simple mechanics. One can drain the uterus by means of a gauze packing but such methods seem to me illogical.

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I am old enough to recall the time when we believed that the best way to drain an abscess of the appendix was by a gauze packing. One of our gifted surgeons, Dr. Robert T. Morris, who has a trenchant pen, dealt a death-blow to this practice when he dubbed it "abdominal taxidermy." Packing the uterus is not without its disadvantages and its dangers. While such methods are frequently justified, it might be borne in mind that the uterus is an organ which resents the presence of a foreign body and, as we all must admit, sometimes quite strenuously.

The other essential is thorough asepsis which is not difficult of attainment. Aside from the usual and customary sterilization of hands, gloves, instruments and solutions, in addition to the preparation of the vulva, vagina, cervix and cervical canal and the sterilization of the cervix and canal by means of iodine, mercurochrome, merthiolate, or similar agent, it is wise to have at hand a lighted spirit lamp and to flame the business end of the curette each time before it is introduced into the uterus. I do not follow the practice of removing the curette at the end of each downward stroke, withdrawing instead only when I feel it is clogged. I find that the debris is expelled by uterine contractions as soon as it is fully loosened and free. If a dilator is used, I flame that also, simply because I feel a sense of security by so doing. The toilet is completed by simply swabbing out the vagina with pledgets of sterile gauze to remove the debris and blowing in, with a powder-blower, a moderate amount of boric acid. I see no occasion for using tampons after a curettage. In using tampons for other purposes, either vaginal or intrauterine, I have a strong preference for boric acid. It is claimed that its antiseptic powers are comparatively weak but I have much regard for any agent which will enable a patient to keep a vaginal tampon *in situ* for several days without its becoming offensive.

If hemorrhage occurs after the use of the curette, it almost invariably is because remnants remain. On one occasion, I

was called out during the still midnight hour on account of hemorrhage after I had cleared out the uterus in a case of abortion. I told the husband, when he summoned me, that I could not understand how his wife could possibly be having a hemorrhage since I had made sure that the uterus was entirely empty at the time of my previous visit some two or three hours before. On my arrival at the house I found that the hemorrhage had been purely imaginary, the husband having been sent hurriedly after the doctor without anyone having had sufficient sense to verify the wife's statement.

In abortion and miscarriage, the finger is the best curette as a rule. In the earlier months the finger can reach the fundus, while in the later months the half hand can be introduced. There is an intermediate period, however, where it is extremely difficult to reach the fundus and cornuae by either of these methods. Here, the auger curette has been of great service to me. It must be used with discretion and, if a sharp uterine contraction should come on, its use suspended for the time being, otherwise there is danger of perforation. Used with care and understanding, it is a very satisfactory instrument.

When called to an abortion case, it is always wise to take the temperature of the patient and if this is above normal, it will usually be found that it is a criminal abortion. So long as the membranes remain intact and the "seal" unbroken, as in the death of the fetus from natural causes, there is no rise in temperature ordinarily. In abortion cases, if I find a temperature at my first visit, I ask the patient immediately, "Who did this, you or some nurse or doctor?" She will usually deny that there has been any interference but, so far as my experience goes, eventually comes out with the whole story. My first question convinces her that I know what happened and that she may as well confess. There is usually some Senegambian in the coal-bin.

Uncle Eph says, "I've heard that the only way to avoid trouble in this world is to be still-born and fust time I heard

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it, I thought it was the Gospel truth; but Doc Jenkins say it's no such thing, that even then you make a lot of trouble for your folks an' with some kinds of folks it is a big mistake to be born at all. Here's a clippin' he got out of his wallet an' passed over to me.

“Science invents ingenious ways to kill
Strong men, to help the weak and ill
That these a sickly progeny may breed
Too poor to tax, too numerous to feed.”

One thing I forgot to mention in its proper place. In simple menorrhagia, the use of a dilator is seldom necessary if the curettement is done while the patient is flowing freely. The internal os will usually be found sufficiently dilated to admit a small blunt curette, which is all that is required in such cases.

I have been meandering aimlessly, like a trout-brook in a wild meadow, and have gotten back, after many windings and turnings, almost to where I started. I know perfectly well that this is no way to write a medical book. It is not only unsystematic and unscientific but it is reprehensible and absurd. I should have started with a Definition, reviewed the History, taken up the Bacteriology, described the Morbid Anatomy, specified the Complications, discussed the Diagnosis, analyzed the Prognosis, delineated the Symptoms, considered the Prophylaxis, outlined the Diet and ended up with the Treatment, after which I should have appended a Bibliography, all in due and ancient order. If I had started this book after that method, I might have held out for 41 pages (estimated) then, if I know myself, I would have quit in disgust.

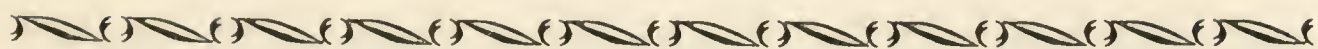
As it is, I rove about; I deviate and swerve and wander without even grace enough to excuse myself for so doing, but I am happy. The moosewood bush, leatherwood, puts out its inconspicuous yellow blossoms early in April before

its leaves appear; its elbowing neighbor, our witch-hazel, scatters its nutlets, drops its leaves, dallies and delays, then bursts into bloom in late November, this without apology or explanation. This is no way to act. One should stick to the beaten track, should stay within bounds, follow a direct course, abide by the rules and the conventions, even if thereby our trout-brook be converted into a ditch. The ditch conforms; it is utilitarian; it is up-to-date and altogether admirable. I pause in admiration — of a sort.

This is the 25th of February, my birthday, and our first spring birds are here. The shore or horned larks come about two weeks ahead of the robins and the bluebirds. Don't ask me why I put this in here. I am just wandering and wondering in an irresponsible way — but spring is coming.

Why not take a little time off to wander and wonder? Before many weeks the shad-bush and the wild plum will be in bloom. What a beautiful sight Plum Island on Lac St. Francis used to be, completely covered with wild plum-trees in full bloom, broken only by an occasional towering basswood and, later, what an abundance of delicious orange-yellow plums which we gathered by the bushel for the friends at home. Then came the curculio, destroying the trees, rendering the fruit unfit for use, marring nature's beauty. I often wonder why other species of plums have been cultivated, developed, improved, and this, the finest flavored and most delicious, has been neglected.

Fifty years ago the doctors all wore driving gloves or mittens made of woodchuck skins tanned with the hair on. They were warm, comfortable, tough and durable, while the fur, though coarse, was far more attractive than many furs now in use, but the old glove-maker is gone and there is no market for woodchuck hides. Some day they will be re-discovered and the lowly woodchuck will come into his own — or, more accurately, be deprived of it.

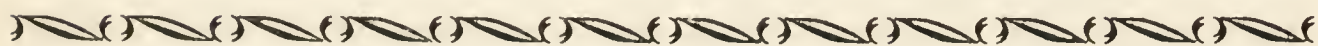


LXXX

THE MENOPAUSE

“The more thou stir it the worse it will be.”

DON QUIXOTE



AT THE change of life women suffer torments, if we are to take the word of many of them as, it seems, we must. Such horrible sudden sweats, such terrible hot flashes, such devastating nervous feelings! Many women do have a good deal of disturbance at this time but, fortunately, do not suffer pain. Some of the ovarian preparations — like theelin — have proved serviceable but I have had very satisfactory results from a little pill of aloin, strychnine, belladonna and ipecac made by various pharmaceutical houses. They are obtainable anywhere but are best known under the title of Lapactic Pills. The dose is, ordinarily, one or two at bedtime until such time as the flashes, endocrine and nervous disturbances cease. If the symptoms recur the pills are resumed. Happening to give these pills in certain cases of sluggish bowels in women at the menopause, and having them repeatedly report that they likewise relieved hot flashes, I naturally followed this open lead. They are easy to take and, compared with the organic extracts, quite inexpensive. Phenacetin is sometimes useful, while gelsemium has been of service in many of the nervous disturbances occurring at this period of life.

The patient should be impressed with the fact that at the menopause, such reflex and endocrine phenomena are to be anticipated, but that they are of slight importance, otherwise some of these cases given to introspection are prone to suffer from hot flashes until they die of senility. The term “change of life,” as used to cover all ailments occurring in women be-

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tween the ages of thirty-five and sixty, should be scrapped. These refuges of the careless, the lazy, and the incompetent, have been grossly abused. I recall being summoned one night to see a woman at a farmhouse some miles away, who was suffering from indigestion and cramps, having vomited once. She informed me immediately on my entering the sick room that her family physician had told her, when she consulted him the previous week, that the whole trouble was due to change of life. Her contour was suggestive, since coming events are prone to cast their shadows before, and one hand placed on her abdomen showed she was already in labor. The husband was hurried off to the neighbors for such assistance as was immediately available; an impromptu outfit of baby clothes was assembled, the patient meanwhile insisting strenuously that I must be mistaken. The prompt arrival of a lusty boy saved the necessity of argument.

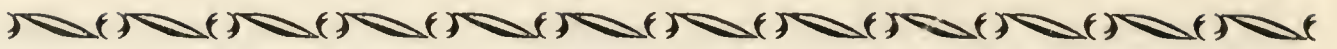
We had a sanctimonious old Irishman whose sister was near the end of life's journey. He said, "Mary, ye should be resigned and contint to lave this world of throuble and go to your hivinly home where ye will meet Aunt Ellen an' Cousin Mike an' Uncle Dennis and the rest of the McDermots."

Mary meekly murmured, "If they're *there*, Archie."

The occurrence of all kinds of troubles due to "change of life" is likewise open to reasonable doubt. It is wise to avoid this "diagnosis." Most nervous women, or to be brief, most women, are not benefited thereby. The chief ailment in many a chronic and incurable female patient is an inability to forget herself. Else why should she be afflicted during the rest of life's journey with a complication of the pip, the jitters, the willies, the fantods, the mollygrubs and the heebie-jeebies? Echo. Please answer that call. Some of these ancient dames and damosels should be advised to get busy about something else. There is a lot of work to do in this world, things that need doing and a lot of things that need undoing,

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if you ask me, which you haven't, so far. When a few favored classes get down to a 30-hour-a-week basis, the rest of us will be kept mighty busy. At the present time bureaucratic agencies are doing a lot for us, and to us, but there are still a few real workers left.

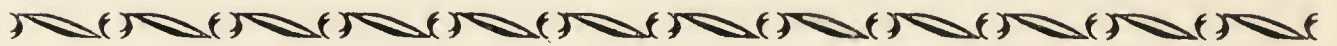


LXXXI

HYSTERIA

“When such are calling names and making faces
And all the world’s ajangle and ajar,
I meditate on interstellar spaces
And smoke a mild seegar.”

BERT L. TAYLOR



WOMEN have troubles aside from those to which they are lawfully wedded. One woman came into my office recently, dropped into a chair with a sigh that wrung my heart and announced that she was “that nervous she could neither set nor lay.” Despite their newly achieved equality with the men, they still seem inclined in times of emotional stress to revert to their own time-honored methods rather than to employ the means of relief so commonly adopted by males. With women, an attack of hysteria has much the same etiology as an outburst of blasphemous profanity in the opposite sex. Neither is to be unreservedly commended.

Medicine is progressing rapidly. If one looks back for fifty years or so, he will note many changes and one of the most beneficent and far-reaching of these is the treatment of hysteria. The ancient and now discredited treatment of hysteria by hydrotherapy is, fortunately, a thing of the past. In select circles it is no longer considered proper to dash a pitcher of ice-water over the lady who is earnestly endeavoring to tie her lovely figure into picturesque and attractive bow-knots. Such methods are crude, a relic of by-gone days; moreover, they are frequently resented, not only by the lady who is starring in the performance, but by her friends and relatives. The accepted method, sanctioned by our best authorities, is a striking advance in the art of medicine and one whereat the people do marvel greatly.

We give a full dose of apomorphia, gently insinuating it

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at some suitable spot under the lady's skin. I was about to write "some accessible spot" but in these modern days this would not be in accord with the spirit of the times. We have innumerable laws on our statute books but the latest edition of today's paper does not record any new law requiring distinct enunciation of the first two syllables of apomorphia. The physician then, with watch in hand (or on his wrist) and a benevolent expression on his countenance, remains quiescent for what he deems a proper length of time and then suggests that a wash-bowl or other similar receptacle be procured, intimating that she may become nauseated. She does, invariably, and the physician relies on first principles and lets nature take her course. If good judgment is exercised and the matter rightly timed, the suggestion of procuring the receptacle will be timely and the anxious friends will be simply pop-eyed at his prescience, delighted with the sudden relaxation of the patient and charmed with the sedative and secondary action of the apomorphia, accent on the last two syllables invariably, please.

Many nervous patients (women being no exception) crave sympathy, but it must be given cautiously, dispensed with judgment in almost homeopathic doses, else all sorts of difficulties will arise, some of which are much more unpleasant than any of the others. In susceptible individuals, even one moderate dose of sympathy may prove habit-forming and create an incessant desire for more, which is indeed deplorable. It is quite as unsuitable as the use of a depilatory for a case of piles. While one does not have to procure a government permit in order to administer sympathy, as is the case under the Harrison law if one desires to prescribe apomorphia, it should be closely restricted and kept under rigid control. A cheerful optimism or even a little harmless kidding, though it may not be appreciated at the time, has a better effect in the long run. Some of our overcompassionate medical pundits might try this as a curative agent, even though out of practice in the demure art of cheerful persiflage.

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Hysteria can imitate many organic and serious maladies and is itself not free from simulation. I recall where one woman on four successive nights sent her husband three miles to the nearest telephone, with an urgent message for me to drive my leg-weary pony eight miles over frozen and almost impassable November roads, to a case where I could look for no reward either in this life or the next. I could understand and appreciate her desire to get even with her husband but I failed to see why I should be subjected to much greater punishment for a quarrel in which I had no part.

One lady of somewhat similar mental make-up said during the course of a general sick-room conversation, "Yes, of course, I know that a doctor must sometimes get very tired, but when I wear one doctor out, I simply get another."

After that remark, I saw to it that she never got a chance to wear *me* out.

LXXXII

INFANT FEEDING AND CARE

“Bachelor’s bairns are aye weel bred.”

Old Scotch Saying

THIS glorious land of ours which was discovered by a Dago, is owned by the Jews, is run by the Irish and censored by the A.M.A., is littered with placards and deluged with advertisements of infant foods. We hope the vast interstellar spaces escape. Each manufacturer has the one and only perfect product. That this savors slightly of blasphemy matters not at all. That the Author of our being is likewise the Creator of breast milk, is an outworn idea that has fallen in the march of progress. Modern science has beaten His product to a frazzle. Why go back to the reign of Tiberius?

Despite all this, there are a few of us who have a feeling that the breast milk of a healthy mother is still the best infant food for babies, else why the baby in the first place and the waste of Grade A Raw following its advent? We believe that a woman who is fit to marry, who has proved herself capable of bearing children, should be willing to nurse them when they arrive. Some do, but far too few of them.

Some time ago, a young and apparently healthy woman came into my office and asked me what was the best food for her baby. I told her that Mrs. Murphy’s was, in my judgment, incontestably the best. “But my milk has dried up on me; it grew less and less and now I have hardly any,” she protested.

“When it grew scanty and the baby was not satisfied, you took the advice of some of your friends and nursed and fed the baby on the bottle alternately. A little later you adopted the plan of feeding the baby during the day and nursing him

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at night; meanwhile, of course, you were careful to avoid eating fresh fruit and green vegetables, lest they give your baby the colic."

"But that is exactly what I did, Doctor."

I said, "Madam, please don't be offended if I speak plainly. Your baby's life may be at stake. It wasn't milk you lacked, but brains. You were brought up on a farm. You know that in the winter, when you want to dry up your cows, you omit every other milking. You know that, when you turn your cattle out to grass in the spring, your milk output from the dairy is doubled. You will perhaps recall that I told you at the time of your confinement that if you had insufficient milk you were to let me know. You have followed the wrong plan, taken the wrong advice, and have gotten in wrong all the way round. However, we can probably help you out by increasing your milk or by furnishing some substitute which the baby can assimilate."

There are some women who are not able to nurse their babies. They are not Ayreshires or Jerseys but Longhorns and Herefords, running chiefly to beef. Some women are physically unfit. Some do not want to be tied down to a nursing baby. The latter variety raises the hackles on the back of my neck. I can't find the hackles but they must be there; the sensation is unmistakable. Moreover, these old women of both sexes (to use a phrase borrowed from Hippocrates) who advise nursing mothers to put their babies on the bottle, make me as profane as Big Bill Condon. When he simply has to curse or break a blood-vessel, he says, "By Dang!"

There are other women who do not nurse their babies because they lack the maternal instinct. They did not want any babies in the first place. Our local Italian fruiterer summed it up when he said, "Alla aila data chap, he no gotta da ambish."

Many children have the kind of "colic" that is relieved only by an abundance of good, warm, fresh milk. The

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mother needs proper dieting during pregnancy and during the period of lactation. I have yet to see a case of infantile colic caused by the reasonable use by the mother of fresh vegetables and fruit. When it is necessary to supplement the breast milk, we find in country practice, where milk is plentiful and can be obtained in good quality, that next to breast milk, a properly modified cow's milk is a satisfactory substitute. The mother's milk has more fat, more albumin, more sugar and far less casein than cow's milk. It is the excess casein, as a rule, which makes cow's milk disagree. I have seldom encountered fat indigestion.

The problem is to get rid of this excess casein in cow's milk without, at the same time, diluting the butter fat, in which the milk is already deficient. Very many methods have been tried, in the effort to convert it into what would at least approximate breast milk, but the methods are often too complicated and troublesome and the final result frequently unsatisfactory. The method I have followed for many years is so simple that it is readily understood by any mother; it is labor saving in that the food is prepared with a minimum amount of time or trouble; it is economical since the cow's milk represents practically the entire cost, no expensive apparatus being required; it is entirely satisfactory in its results, since the babies almost without exception thrive on it.

Two Mason glass fruit jars are required, or jars of this general type. They should be tall rather than squat in shape, holding one quart each. A strip of ordinary zinc oxide adhesive plaster an inch in width is applied to the side of each jar to serve the purpose of a graduating scale. A bent glass tube (the glass medicine tube to be found in every drugstore will serve the purpose, if need be) is procured, to which is attached a piece of flexible rubber "nursing bottle" or other tubing. This forms a syphon. No other apparatus is required.

In the morning one of these jars is scalded, filled to the neck with fresh milk, set in a cool place with a piece of clean

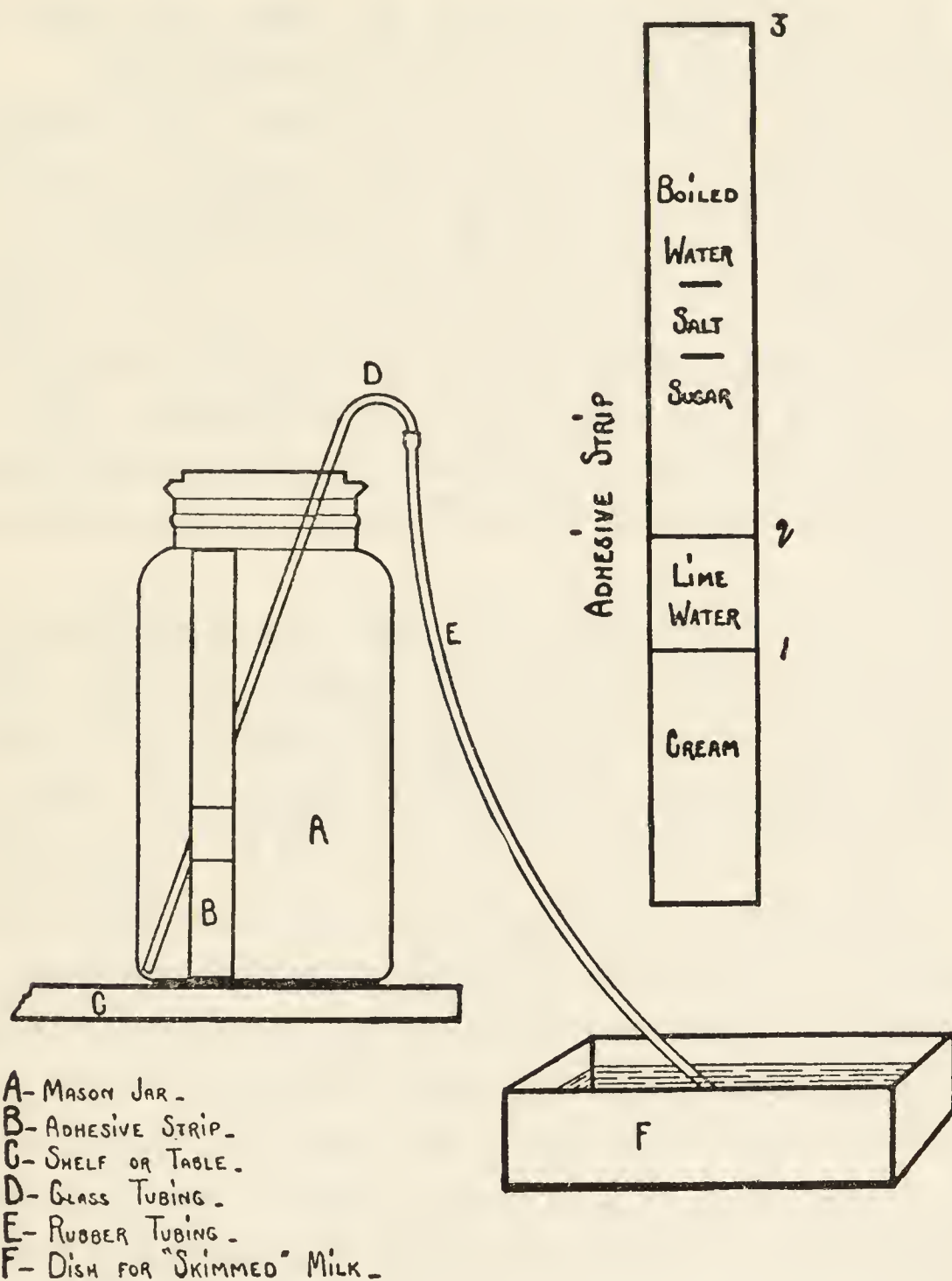
muslin to cover the top in order to keep out the dust. The glass cap should not be used. The jar is set in a place where the temperature is such that the cream will rise to the top. Twelve hours later the second jar is set in the same manner and the contents of the first jar is prepared for the use of the baby. This is done by dropping the glass end of the syphon into the milk as the jar sets on a shelf or table; suction is applied to the end of the rubber tubing, and as the milk starts to flow, the "skimmed" milk containing most of the casein is drawn off into some other receptacle without disturbing the top layer of milk and cream. When this top milk has settled down to the lowest mark on the scale, the syphon is at once withdrawn.

We now have our top milk in the bottom of the jar. Lime water is added, about four ounces as a rule, to counteract the natural acidity of cow's milk, which is greater than that of breast milk, and the additional acidity due to the milk having been set for twelve hours. The jar is filled to the original level at the neck of the jar, with water, previously boiled. The modified milk is still deficient, in that much of both the salt and sugar contained in the cow's milk has been syphoned off, therefore a pinch of salt and sufficient sugar to sweeten it should now be added. I have never been able to perceive any difference in results when milk sugar instead of cane sugar was used, although milk sugar should be better, from a theoretical standpoint.

The mixture is now shaken and is ready for use, the requisite amount being warmed before filling the nursing bottle. At the end of the next twelve hours the cream should have risen on the milk in the other jar. By using two jars and alternating them, a supply is provided for as long as the food may be required. It seems unnecessary to state that the jars and syphon must be sterilized. In hot weather, the milk must be set in a cool place (but not too cold) so that the cream may "rise" properly. If the weather is excessively warm and no ice is available, the mixture, after it is modi-

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fied from the raw milk, should be pasteurized, if a sufficiently cool place in which to keep it is not available. The diagram appended is explanatory of the simplicity of the process and the apparatus required.



No hard and fast rule can be laid down as to the amount of "skimmed" milk to be syphoned off. Children vary in age, strength and digestive power as well as in appetite. In a general way it may be stated that the milk should be syphoned off to a level of about an inch and a half for a child three weeks old. In proportion as the child grows older, the levels 1 and 2 on the scale shown in the diagram should be gradually raised. When the child is about a year old, these levels

will, under usual conditions, reach the top mark and whole milk can then be substituted.

A few simple rules in the use of this modified milk have proved of service.

If the child should become ill, from any cause, the strength of the food should be reduced temporarily.

If the child vomits the food frequently, the amount of lime water should be increased until vomiting is controlled. If enough lime water is used the vomiting should cease.

If the milk is too rich or too strong, *i. e.*, if an insufficient amount has been syphoned off and too much top milk left in the jar, the child will nurse at long intervals, will vomit occasionally, will have loose bowels as a rule, in endeavoring to get rid of the surplus, but will usually remain plump and contented.

If, *per contra*, the food is too thin, too much diluted, the child will be peevish, want to nurse too frequently, will wet his diapers excessively in getting rid of the surplus water in the food, will have a distended stomach from taking too large a bulk, will seldom vomit and will be constipated. To put it differently, he will get all he can and will endeavor to hang on to all he gets. He will be poorly nourished.

Incidental ailments and individual peculiarities will disturb these simple working rules. Children do not always conform to fixed rules. Each case must be treated individually. These rules will, however, prove of much service in a general way. That this method of modifying milk has proven satisfactory is shown by the number of mothers who come or are sent to me for instructions in preparing food after this manner. I can recall but one instance in which the mother stated that this method did not work well. Investigation showed that, on account of a prejudice against the use of lime water, she had omitted it entirely.

The above formula may seem, at first glance, rather complicated, but once the idea is grasped and the food is so prepared a few times, it will be found a simple and labor-saving

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device in that the "compounding" is done but twice a day, meanwhile the food is always ready for use, simply requiring that sufficient for each feeding be warmed just before giving it to the child.

If, under this plan of feeding, the bowels are constipated and increasing the richness of the food does not remedy this, the child should not be given cathartics if it can be avoided. Oatmeal water may be substituted for the plain sterile water. Barley water can be used if preferred. A small amount of milk of magnesia may be added to the lime water or a glycerin suppository or a soap-stick used for immediate results.

When a modified milk of this kind is used merely to supplement the breast milk, it should not be used alternately with the mother's milk. *Both breasts should be emptied at each nursing*, then, if the child is still unsatisfied, the modified milk should be fed with a spoon. Milk comes so easily through a rubber nipple that the child will, in all probability, refuse the breast, thus defeating our best efforts. We are raising enough slackers and shirkers under Federal auspices without this.

If the mother is put on a proper diet and both breasts emptied regularly at each feeding, the natural tendency is to an increase in the quantity of the breast milk. In most cases so managed, artificial feeding can eventually be abandoned, a consummation devoutly to be wished.

Our problems in raising children are not always so readily solved as those of the old darkey "mammy" who, when asked by the visiting nurse what method she had followed in raising her large brood, replied, "Ah raises 'em with a barrel-stave and Ah raises 'em frequent."

There is the vitamin question, for instance. Hippocrates claimed that there was a mysterious "aliment" in many natural foods which was essential to proper growth. It is still mysterious in a large measure. We have made progress since his day but not sufficient to warrant us in high-hatting him. We have Vitamins A, B, and C, likewise a few others, but

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much of the alphabet is still missing and the ABC's, even with a few additions, do not constitute a liberal education.

We are reasonably certain that Vitamin A is of much use in certain ophthalmic troubles, in lactation and in prevention of some types of urinary calculi. It is soluble in many fats but is destroyed by prolonged exposure to the air. It is found in egg-yolk, milk and butter, oranges and grapefruit, carrots, raw cabbage and many green vegetables and salads, in tomatoes, grains and in cod-liver-oil.

Vitamin B is of value in neuritic disorders of some types. Heat destroys it. Milk, wheat-germ, lean meat, pineapples and oranges, kidney and liver contain it. It is water-soluble, a pellagra preventive, apparently arrests certain forms of cataract. Source, chiefly yeast.

Vitamin C is of great value in scurvy. It is soluble in alcohol but destroyed by heat. It is found in citrus fruits, tomatoes, apples, bananas, egg-yolk and cabbage. It is claimed to prevent tooth decay, but I would pin more faith on bone meal.

Vitamin D is chiefly of service in rickets. It is fat soluble and assists in the assimilation of calcium. It is found in cod-liver-oil, milk and the yolk of the egg. Butter contains a moderate amount. Natural sunlight and calcium compounds assist its action. Powdered beef bone is an excellent way of giving the calcium.

Vitamin E has some influence on sterility. It is not the sole factor, obviously, merely an accessory.

In the country districts as we have seen, strictly fresh milk is readily obtainable and the best all-round infant food for bottle-fed babies is on the whole a properly modified cow's milk. Despite this fact, we see many children fed on condensed milk, which may be quite proper under some conditions, but not when fresh "live" milk of excellent quality is in abundant supply. A well-fed baby seldom is fussy, and while we hear of many colicky babies, I find that a very large percentage of these are not really colicky but are suffering

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from indigestion that is due to improper food, or if the food is of good quality, to insufficient amount. It may be that they are not fed at frequent enough intervals.

It is impossible to lay down rules in regard to the frequency of the feedings and make babies conform. So long as babies come into the world individually and not on the conveyor plan like the flivver cars, so long will they retain a measure of individuality. We incubate chickens and brood them in extensive plants, securing quantity production, but there has been no advance worth while in the way human beings are brought into the world. In calling attention to this defect, I trust that nothing further will be needful and that the proper authorities will heed this timely suggestion so modestly submitted.

The colic of many infants is due to too great dilution of the milk. Like every rule, there are exceptions to this one. While most children will cry or whine and fret continually if they are hungry, there are some infants of a different type who will simply lie in a semi-stuporous condition and waste away, when the sole thing that ails them is insufficient nourishment. I frequently meet with just such cases.

To use a homely illustration, in former days the country doctor did a lot of driving with horses in drifted roads in mid-winter and frequently encountered drifts which were impassable until shoveled out. Some horses, when so stalled in a deep drift, would paw and struggle until they either broke a tug or whiffle-tree, exhausted themselves or managed to pull the sleigh through. Others of a different temperament, would simply lie down in the drift and stolidly await help or death by freezing. I have had no lengthy experience with the latter kind for I usually soon sold such an animal to someone with whom I was not too friendly. Whether the corresponding type of infant is worth saving or otherwise is an open question. Fortunately, this is not one of the matters which we are called upon to decide, for we can pass the buck to Providence. Forced feeding is indicated.

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One case may be cited briefly to illustrate the other type. One evening, not long ago, a couple carrying a young baby entered my office. The mother stated that the child had been yelling continuously for two days and two nights; that neither she nor the baby had slept a wink; that she was utterly worn out. The baby looked healthy enough but not too well nourished and was raising such a racket that it was difficult to make ourselves heard. My wife gave me a glance of interrogation and I nodded. She said, "Mrs. Gardner, you look tired. Let me take the baby for a while."

She took the baby out to the kitchen and in a few minutes returned with the child sound asleep. Mrs. Gardner said, "My God, Mrs. Macartney, what did you do to my baby?"

I laughed and answered for her, "I think she filled him up to the brim with nice warm milk."

In convulsions of young children, it is usually recommended that they be immediately given a hot bath. Like most recommendations of this sort, it should be qualified. If the convulsion is due to some lesion of the central nervous system, the hot bath may be contra-indicated, on account of the danger of cerebral congestion or hemorrhage. The child's temperature should be taken before putting it into a hot bath. If there is much fever, the hot bath may be more dangerous than the convulsion, owing to the risk of hyperpyrexia. Aside from the customary treatment, dry cups to the back of the neck are of much service.

Possibly this is as good a place as any to make a few comments on the use of the clinical thermometer. The rectal temperature is trustworthy but may be inconvenient save in babies and bed-patients, for which reason the temperature under the tongue is the method commonly adopted. It is not always reliable. If the patient has had either a hot or a cold drink just before you enter the room, if he has a cold in the head or is a habitual mouth breather, the temperature so taken will be misleading. If he has been walking rapidly on a cold winter day, just before he enters the office, the

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same may be true. The axillary temperature is much more reliable if proper allowance is made for the fact that it registers about one degree lower than when taken by the mouth. In cases of shock, collapse, etc., the mouth, like the nose, may be cold and the thermometer will give a wholly misleading and erroneous record.

I recall one such case where I was called as a consultant; objection was made to one recommendation of mine on the ground that his temperature was subnormal. The family physician had taken it just prior to my arrival and found it to be 95.7 F. I asked how it had been taken and was told it was by the mouth. The patient's hands and feet were ice-cold at the time, as well as his face and nose. His rectal temperature was found to be over 108.

In the average case of convulsions, an emetic should be given and this followed by a brisk purge. I saw one child that vomited up an immense quantity of undigested peanuts that were wholly unsuspected. One can imagine what would have occurred in this case if he had been incontinently thrust into a hot bath when his temperature registered 108.3. Bromide of potassium and chloral will control the seizures as a rule. The chloral is safe in children as the heart muscle is usually sound. Chloroform is effective where quick action is imperative.

If there is a suspicion of lumbricoid worms or other such parasites, a dose of santonine should be given with the purge. Some of our highly intellectual doctors make light of worms, but might profit from a week spent with any veterinarian who has charge of a large dog kennel. They will be convinced that worms will cause fits, at least in dogs. Convulsions usher in many contagious diseases in children, the convulsion here taking the place of the chill of the adult case. A convulsion in a child may be the first definite indication of acute nephritis. Hippocrates says, "It is better that a fever succeed a convulsion than a convulsion a fever." Chalk up one on the scoreboard for Hippocrates. The so-called idio-

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pathic convulsion is simply due to some cause which we have not discovered.

Croupy conditions are of frequent occurrence in children, but of late years there has been a marked change for the better. In croup, we must be always on guard for a diphtheritic laryngitis, since this may occur without the usual signs of fever, pulse disturbance, foul breath, or any visible throat signs. When in doubt, life has been frequently saved by a large dose of antitoxin as has been pointed out in another chapter. Spasmophilia is occasionally mistaken for croup, but if this possibility be borne in mind, the differential diagnosis is comparatively easy.

For the ordinary spasmodic croup of children, which has little resemblance, save in the peculiar cough, to membranous croup, the surest way of securing prompt relief is with an emetic. I find that syrup of ipecac is the agent that is most commonly used for this purpose. It is safe and not particularly disagreeable to the taste, nevertheless it is not well adapted for the relief of spasmodic croup if the attack is severe, for it is altogether too slow in its action. These attacks usually occur during the night and if one desires to get home and so to bed, as Mr. Pepys says, he will do well to give a teaspoonful of powdered alum in syrup or similar vehicle. It is safe, acts promptly and is more reliable. The real remedy for these "croupy" children is, however, preventive. Quit muffling them and use daily frictions of snow or ice-water to the throat and neck. Many mothers object to this but there is usually some neighbor who says, "The doctor cured Georgie that way," which helps us out. Some cases of croup may be allergic in their nature.

In former days when every child going out in winter weather was provided with neckscarf, muffler or tippet, I was accustomed to say that if any mother would tell me how many little red mufflers she had, I could tell her how many of her children suffered from croup. The rule was one for each muffler. When modern maidens began to go about in mid-

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winter with their necks exposed, there were dire predictions as to pneumonia, bronchitis, sore throats, pulmonary tuberculosis and the dickens to pay in general. As some of us had the temerity to predict and as practically all of us can now testify, these prophecies were wrong.

Children complaining of stomach-ache should be examined for more than appendicitis. Potts' disease, malaria, tonsilitis, pneumonia, pleurisy and various other conditions may account for it instead of indigestion or worms. Rickets is so common and shows itself in so many diverse ways that it should always be looked for. Here, cod-liver oil, Vitamin D, the calcium salts and the violet ray are indicated. In our North Country, cod-liver oil is almost a necessity in the rearing of children. As a rule they take it very well indeed. It should be given before meals or some two to three hours after meals. If given clear, or in emulsion, a little salt on the tongue or sprinkled on the oil, makes it more acceptable.

Children who have "night terrors" benefit from a course of cod-liver oil, rickets being frequently present. Gelsemium is of assistance in controlling the nervous system in these cases. If there are adenoids, enlarged or infected tonsils or similar troubles, these should receive proper care. Patients with phlyctenular conjunctivitis and keratitis, corneal ulcers, etc., all benefit from cod-liver oil.

Many children suffer from hernia. One prominent writer says hernia is never congenital. I delivered a breech presentation one time and noted the presence of two inguinal and an umbilical hernia before the head was born. I may be wrong but it would seem to me that this disproved another dogmatic assertion. Hernia in children is almost always susceptible of cure without operation. Umbilical hernias are readily cured by simple strapping with adhesive plaster. The mother should be taught how to apply it so as to maintain constant tension. Usually the straps applied are too short. No other method of treatment has proved so simple and easy in my hands.

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Inguinal hernia calls for a spring truss, the elastic ones proving disappointing as a rule, being open to the defect of giving way under the impulse of coughing, crying, straining, etc. In other words, it does not stand the gaff, giving out on you at the time you most need it. Steel spring trusses should be used.

A lady called me up on long distance one day, telling me that she had three young children, all of whom had hernias and asking me what my fee would be to go to her home and operate on all three. She may have been a bargain hunter but did not sound like it. I told her what it would probably cost her but suggested that she bring them all to my office for examination. I beat myself out of a fat fee but all three got quite well under suitable trusses.

In children I get about 85 percent of cures under the use of trusses; about five percent are not amenable to this treatment because the hernia is of some unusual type or complicated by undescended testicle. The remaining 10 percent of failures are practically all due to the violation of the one essential in this form of treatment, viz. Under no circumstances must the protrusion be allowed to recur. If it is allowed to come down, the treatment must start all over again and this time under less favorable conditions. If, on the other hand, it be properly impressed upon the mother that the hernia must be held back by the fingers when the child is being bathed with the truss off, if she receive proper instruction and the hernia is never allowed again to stretch the hernial ring, the opening is bound to contract and a cure is to be expected in a year or two.

This same plan is reasonably successful in adults if they can be persuaded to use sufficient care in this respect but the older patients do not have the reparative power that we find in children; they are more subject to sudden and unexpected strains and, in a considerable proportion of cases, it is impossible to hold the hernia with any form of truss so far devised. For many old hernias the use of a truss is at best a mere

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palliative treatment. Hernia cases with a chronic cough are difficult to manage by trusses but the same is true in respect to operative procedure. It is folly to attempt a cure of hernia by trusses in a child who has a tight phimosis, which should receive attention first. Constipation should likewise be remedied.

The sense of touch is important. Many years ago a woman from Bombay brought in her baby, a child some eight months of age, for examination. The child was fleshy, had not been ill, but in bathing the baby the mother had felt a small hard nodule in the mid-line about two inches above the navel. There was no mark or discoloration of the skin and nothing to indicate its nature save the feel of it. I told her I thought it was the end of a needle. I advised an exploratory incision to which she strenuously objected, stating that this needle idea was impossible. After some discussion she told me that if I were certain it was a needle, I could operate, not otherwise. This was before the day of radiology and I could only assert that it was my unqualified opinion but could not state it as a fact. She started home with the baby but some of her friends persuaded her to bring it back. Under local anaesthesia I found the head of a needle embedded three-fourths of an inch beneath the skin with the point lodged firmly in the spine, having penetrated both walls of the stomach. On removal it proved to be a milliner's needle three inches in length, very little discolored. How it got there we have never been able to fathom. The baby made an uneventful recovery.

Prolapse of the rectum in children is likely to cause undue alarm. It is readily relieved, provided that it has not been too long neglected, by means of a long strip of adhesive plaster, of an inch or so in width. The child is held with the thighs at a right angle with the body (as in the sitting position), the buttocks are drawn snugly together and held in close apposition by means of the adhesive plaster. This should reach from one iliac crest down and across the buttocks over the

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anus and up to the crest on the opposite side. It should fit snugly with moderate tension. This necessitates careful washing after each bowel movement but the strapping can usually be dispensed with in a fortnight. Meanwhile, the bowels should be regulated so as to avoid straining during defecation. Up to the present time I have seen no case of this trouble that did not fully recover under this simple treatment.

Circumcision is frequently required in young children and it is imperative if hernia is present and there is a tendency to strain, due to a tight prepuce, on urinating. I have circumcised a very large number of children, as a matter of routine in my obstetrical practice and in that of other practitioners. I have had no trouble worth mentioning save in one case.

This one was bad enough. The customary operation was done. There was no jaundice and no history of hemophilia or syphilitic taint in the family. About two hours after the operation, the nurse called me on the 'phone and told me that bleeding had started. The wound was re-opened and all bleeding vessels securely tied. The wound was then sutured with a fine round needle and silk sutures. Bleeding soon recurred from the needle punctures and from the raw surfaces left after liberating preputial adhesions. There was now no definite bleeding point but a continuous oozing. I was unable to control it by pressure, astringents or the electro-cautery. Adrenalin gave temporary control only. Full dosage with the calcium salts and hemostatic serums of various kinds were ineffective. Transfusions failed. The baby lived a number of days under constant and unremitting care, but became slowly but completely exsanguinated and eventually died.

Naevi of various kinds are of frequent occurrence in babies. Many of these will progress if left untreated. The most difficult to manage are the deep-seated cavernous naevi. In such cases I have found repeated punctures with a small galvanocautery point, at a low heat, a most satisfactory method of treatment, leaving but little perceptible scarring and bringing

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about a complete and permanent cure. For the more superficial ones, wine marks and the like, the injection of absolute alcohol with a fine needle is a simple and efficient procedure. Good results are also obtained with carbon dioxide snow but this is not always readily obtainable.

There is an unfortunate tendency to dose babies with medicine for slight disturbances. Why not trust nature in cases of minor import? The average baby is born perfect to the most minute anatomical detail. He is toothless but we know that he will develop 20 temporary teeth, later 32 permanent (more or less permanent) teeth. If he is a boy baby he will develop, along with some other characteristics, a beard. How much credit should the proud parents take for all these countless and foreordained miracles? How much foresight did they exercise at the time of conception? Like the habitant who had a quarrelsome neighbor, I have my own belief. He said to his neighbor, "Mr. Bastien, I do not say you shoot my dog. I do not say you t'row a dead cat in my well, I do not say you poison my pig las' week and den steal de soap-grease I save from heem, but I have my *opinion*."

While an early diagnosis and prompt treatment will save many lives, we meet with many mothers who are merely fussy about their children and such women should be taught that nature can do a great deal if given half a chance. Uncle Eph says, "There was a feller up this way last summer paintin' pictures, good ones, too. Sort of quiet, level-headed chap. No frills. One afternoon he was paintin' up by the lake where I was fishin' for perch. Had a kind of little derrick to hold his canvas and a little flat tray with a hole in it for mixin' his paints. 'Long comes Si Perkins' oldest girl an' she says, 'Oh, Mr. Wilberforce, I just came for a walk by the river path and some of the scenery reminded me so much of the lovely, beautiful pictures you been making. I think they are *perfectly exquisite*!'

"The feller says, kind of dry-like, 'Yes, I believe nature is

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showing signs of improvement,' and he went on paintin'. Didn't stop to talk to her at all."

Years ago it was the custom to hang in the sitting-room mottos made with bright yarns on perforated cardboard, such as "What is Home Without a Mother?" "Home, Sweet Home" "What is Home Without Pie?" and things like that. They were framed mostly in carved black walnut but I always thought that chestnut would have been more suitable. The making of such mottos appears to be now a lost art. For years I have been seeking some survivor of the horsehair sofa period who would make me a motto for my office, one that would be really useful and appropriate in a thousand different ways. It is to read, "You Never Can Tell." Such a motto would be of almost unlimited application. At present I have in mind a small card to be distributed to mothers of young babies. The quotation is from Wallace Irwin and is, I think, not too subtle in its sarcasm.

"When Baby is restless, a bottle I keep
Of Ma Winslow's syrup. It takes
A spoonful of poison to put him to sleep
And another one when he awakes.
He lies in a paralyzed, hypnotized state,
So calm you can see at a glance
That the dear little chick sleeps as sound as a brick
When he's neatly laid out in a trance,
And I'm sure every mother could learn, if she would,
The knock-out drop method to keep Baby good."

The problem of raising a family of children is a serious one under modern conditions. It was doubtless as serious in all past ages as at present, with minor variations, naturally. Cain seemed to have been a wayward youth and Adam may have had troubles that were not a matter of record. We cannot all accept these responsibilities as light-heartedly as Jerry Charette. I was leaving his house just after the advent of his last pair of twins. His next-door neighbor, Mrs. Muir, a

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kindly but very sober-minded old lady, said to Jerry, "Mr. Charette, isn't this perfectly terrible?"

"What is so terrible, Mrs. Muir?" asked Jerry.

"Why, you are a man of limited means and a large family and now you have two more mouths to feed."

"I t'ink me dat's fine, Mrs. Muir. Me, I am plant four acre of ras'berry an' I am raisin' my own pickers."

The tendency in the present age seems to be to give children full opportunity to "express themselves" and to allow them to follow their own inclinations so far as possible. If this is at the expense of proper training and right discipline, it is open to criticism. Personally, I believe in giving them a large yard to play in with a high wall surrounding it. In other words, plenty of liberty with definite restrictions.

Little Georgie was playing one day with some neighboring children across the street when his mother came to the door and called, "Georgie, I want you. Come home now."

"Yes, Maw, I'm coming," said Georgie.

Presently she came to the door again and said, "Georgie, you march straight home now. I don't want to have to speak to you again about it."

"Yes, Maw. I'm coming right away," said Georgie.

After a while she again appeared at the door. "Georgie, *Georgie*. If you're not here in five seconds you know what *you'll* get when your father comes home."

"Sure, Maw. I'm coming."

The neighbor woman then appeared and said, "Georgie, I like to have you come and play with my children but your mother has called you three times already and I think you ought to go."

"Huh! That's all right," said Georgie. "When she comes to the door and just looks at me and says, 'George Henry Augustus Smith,' you'll see me get a gait on."

Moral: It is just as easy to say "George Henry Augustus Smith" the first time.

One incident connected with parental training gives me

the heartache. A woman from a neighboring town came to my office and said, "My little daughter is outside and needs a tooth out. I told her you just wanted to see her tongue. When she opens her mouth be all ready to pull her tooth." I tried to show her the error of her ways but the little girl could not be induced to enter my office and her mother, much to my disgust, dragged her in and held her fast while I made the extraction.

About a month later she had another aching molar and her mother again tried a similar method. "Why lie to your own child?" I asked her bluntly.

Leaving the woman in the office, I went out to the reception hall, sat down by the little girl and said, "Mary, listen carefully, now. You have a bad tooth that will have to come out. Nothing else will do any good. If you fight and struggle, we will have to hold you as we did before and grab it as best we can and we may hurt you a lot. On the other hand, if you will come in, sit down in the chair, open your mouth wide like a good little girl, I will be just as easy and careful as I can not to hurt you any more than necessary. Let's try it that way this time."

She smiled, put her little hand in mine and, with tears in the eyes of both of us, we went in to have our troubles over with in about three seconds. What a sorrowful thing that a six-year-old child should have more confidence in a stranger than in her own mother! My voice breaks when I tell this.

One Sabbath morning Mrs. Mulholland came into my office somewhat keyed up. She had brought her baby down for baptism and Father McGarvey asked, "And what will ye name the choild?"

"Claude Cecil," said Mrs. Mulholland.

"Tut, tut. We'll have no such fancy names as that. Choild, I name thee James Pathrrick Mulholland," and this stands on the parish register, but he is known otherwise as Claude Cecil so I don't know who really won out.

LXXXIII

TONSILITIS

THE malign influence of infected and diseased tonsils in this day and age needs no discussion for the subject has been so thoroughly threshed out that we can let the straw lie. In acute tonsilitis, I am convinced that the purely local treatment by means of applications of various antiseptic agents to the tonsillar tissues is on the whole productive of more harm than good, that in most cases a combination of both general and local treatment is indicated. Aspirin and its congeners will undoubtedly relieve the pains and aches together with the febrile disturbances which so commonly accompany an acute attack. These symptoms, however, are due to toxæmia, and require eliminative treatment in order to avoid complications, such as nephritis, which frequently follow an acute tonsilitis.

Two to five grains of calomel, followed by a saline purge, has afforded me more satisfaction than any other line of treatment. Coincident with each watery evacuation thus produced, the general malaise, backache, boneache and headache will let up a notch, and I feel confident that the practically entire freedom from complications and the rapid recoveries in my cases were the direct results of the elimination of the poisons generated by the infection. It is, of course, true that acute tonsilitis naturally tends to subside in a few days, yet the relief afforded by this plan has been so positive and the results so uniform as to be unmistakable. It has gradually become my sheet anchor in this trouble, and I do not give it in 1/10 grain doses, but in a single dose of four or five grains. The giving of fractional doses is not infrequently an utter absurdity save for the psychological effect. Not uncommonly,

such a procedure keeps the patient nauseated and upset much longer than is needful.

Having seen some of our old practitioners give a teaspoonful of calomel at a dose, representing approximately two drams of the pure drug, with only the happiest effect, I have never had any great fear of it, providing always that no incompatible is given at or near the same time and that the dose of calomel is followed up by a saline cathartic. There is little danger with large doses as they are likely to purge thoroughly while the small doses are more apt to be absorbed. One-twentieth of a grain of calomel, three times a day is, in fact, a very satisfactory way of bringing the system under the influence of mercury in treating syphilis; here the alternative action through absorption is the object to be sought and not the evanescent purgative effect. Where one feels the need of a placebo, and placebos are quite useful in many instances, the fractional doses of calomel sometimes are useful in a twofold way. They certainly served a purpose in the years when homeopathy was more rampant and aggressive than it is at present.

Taken as a whole, I have gotten well over my fear of operation during an acute attack, if complications are threatened. Formerly, I was accustomed to wait until all the acute symptoms had subsided. I still follow that plan in the main and do interval operations by preference as I would with an appendix, but I believe it is no more justifiable to postpone a complete enucleation in quinsy than in the case of an appendix that is suppurating. The treatment of an acute suppurative tonsillitis by purely local measures is like making soup of your own ears, a very temporary and unsatisfactory expedient.

Tonsillectomy is indicated in two major classes of chronic tonsillar troubles, where the tonsils are the seat of infection and where they are sufficiently enlarged to obstruct respiration or interfere with Eustachian drainage, thus giving rise to middle ear troubles. Forty years ago, the tonsils upon which we operated were of the latter class chiefly, where the

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patient slept out loud, and we considered that we had done our full duty if we guillotined them off at the level of the anterior pillar, and the noises ceased to annoy.

At that time, adenoids were known as the third tonsil, and this was not at all an inappropriate name. We considered it unwise to remove the tonsils in toto and left a portion of them to function, much as we now do with the thyroid. It gradually dawned on those of us who were doing much tonsil work that such clipped tonsils were prone to give trouble again, thereby necessitating further operation, that such operations failed to prevent quinsy and that these hypertrophied tonsils were not necessarily the worst offenders, but that the small and deepseated ones surrounded by an area of purplish congestion running up the anterior pillar, needed removal even more urgently.

In the days of which I speak, concealed plumbing was in vogue, and in severe weather when a pipe burst inside of a partition or where it ran between the joists of a floor, it meant a lot of damage. We slowly came to understand that it was the submerged tonsil that was the more dangerous rather than the simple hypertrophied tonsil, with its comparatively open plumbing giving the tonsillar pocket with its embedded crypts free vent. We found that quinsy or peritonsillar abscess was simply the result of tonsillar infection with obstructed drainage and was only secondarily peritonsillar. Tonsils, unlike babies, do not recur after complete removal.

With a measure of chagrin, I look back upon a few cases of stooped shoulders, in which I tried nearly everything from moral suasion to shoulder braces without avail, only to see them straighten of their own accord within a short time after I removed tonsils and adenoids. Knowing something of the attitude and somewhat similar stoop of cases of long-standing asthma and emphysema, I should have sooner appreciated what chronic respiratory obstruction was likely to do to these patients. However, let him who never played the fool criticize us for what was not heretofore known. Nor am I alone

in my lack of observation and deductive reasoning so long as a large number of surgeons persist in removing tuberculous glands of the neck, glands definitely belonging to the tonsillar group, without removing the obviously infected tonsils which constitute the primary focus. Adenitis, involving lymphatic glands of the neck or other regions, is seldom primary, being usually secondary to some localized infection in a very definite area which is drained by the lymphatics involved. A removal of the glands, without proper attention to the original focus, simply invites a recurrence.

The presence of decayed or infected teeth is another source of a similar involvement of the neck glands and sufficient emphasis is seldom laid on this matter in our textbooks. I have repeatedly seen patients with badly infected tonsils or with decayed teeth, operated on by skilled surgeons for enlarged cervical glands. It was but natural that many of these operations were followed by wound infection, disfiguring scars and recurrences. Evidently it had not occurred to these operators that there was a primary focus which merited much more attention. Once the primary focus is removed, the enlarged glands often fade out of the picture without further attention.

That the tonsil is one of the commonest seats of focal infection has been amply demonstrated to those of us who do much radical tonsil surgery. Relief from recurrent colds, from rheumatism in its various manifestations, from some forms of neuritis, etc., is what we expect. By radical tonsil surgery I mean not only removal of tonsils but adenoids and any similar formation in the faucial region. Such surgery usually has a happy effect on eye ulcers, on many other eye troubles, in the prevention of middle ear diseases, mastoiditis and deafness; its influence on many cases of chronic or recurring chorea, heart disease, on many nervous affections of obscure nature and on the stooped shoulders of adolescents and a host of other ailments, can hardly be questioned.

I am convinced that tonsilleectomy should be done in the

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majority of cases where the patient has had the second attack of acute nephritis, and if the patient gives a history or shows signs of tonsillar infection, such removal becomes imperative if one wishes to avoid serious kidney damage. A review of my case histories leaves little question on this point. In the younger subjects I rarely find the tonsils alone involved and when I speak of a complete enucleation, it is understood that I include any adenoidal hypertrophy as well, or any other similar tissue which is included in the ring of Waldeyer. Their treatment is, or should be, practically inseparable.

There is still some protest that tonsils are being removed unnecessarily. Unfortunately, the infected tonsil and the gangrenous appendix are not yet obsolete, or extinct, nor are they likely to be for some time to come. Cases of needless removal doubtless at times occur but I think it is a safe statement that for each such case there are a hundred in which failure to remove the tonsils constitutes criminal neglect. All great reforms come slowly. If an occasional over-operating be wrong, is an habitual under-operating any the less immune to criticism?

Infected tonsils are a potent cause of rheumatism. Rheumatism in turn is prone to affect the heart, producing endo-, myo- or pericarditis, valvular disease, etc. Once the heart is seriously damaged, any attempt to remove the primary cause by a tonsillectomy becomes, in exact proportion to the extent and severity of the heart trouble, a serious operation. Anyone who can recall the once popular game of cut-throat euchre where, when one of the three players made the trump, the other two immediately joined forces to beat him, will understand exactly what I mean when I say that the operation should be done early, before there are too many odds against us.

Many years ago, Dr. Dana, an eminent New York physician, reported in detail the case of a young woman who had an excessively high temperature without any other definite febrile disturbance. The London *Lancet*, in commenting on

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this report, said that in view of Dr. Dana's recognized standing in the profession it was wholly unnecessary for him to have brought in, as he had done, corroborating testimony from his associates, but the editor desired to warn Dr. Dana that even *his* hitherto unblemished reputation would stand but *two or three degrees more Fahrenheit*. I trust that my readers will exercise a similar forbearance if any of my statements seem unusual.

LXXXIV

TONSILLECTOMY

“Of such material wretched men were made.”

BYRON

THE operation of tonsillectomy has very properly superseded the old operation of tonsillotomy, and its advantages need no argument at this late day. There are nearly as many methods of enucleation as there are enucleators. We have a wide range of choice and the individual operator is entitled to his own preference, doubtless doing better with some method that he has thoroughly mastered than by following some technic with which he is not so familiar. In other words, the soup-ladle has little to do with the quality of the soup, provided it be clean.

My routine, which slowly developed during forty-eight years of tonsil operating has reached the following stage. I give a preliminary course of calcium lactate, which I have good reason to believe has an excellent effect in preventing hemorrhage. I give a purgative on the morning of the day preceding operation, early enough so that there will be no trouble during the operative procedure. I allow no food or drink of any kind on the morning of operation, operating where possible early in the day to avoid discomfort to the patient in going for a long time without food.

I operate, where there is no contra-indication, under ether anaesthesia, using a Wolff gag and tongue depressor which has proved very satisfactory. I operate with the patient in the dorsal position with the head hanging well over the end of the operating table, and in this way avoid the risk of blood or other fluids entering the trachea. I find this position better adapted to my requirements than any other. I seize the tonsil with an ordinary pair of bullet forceps which I prefer to most

of the special tonsil forceps, drawing it well out of its bed to avoid danger of injury to any of the deeper structures, liberate the tonsil all around with a hooked or angular knife, taking care to keep outside but close to the tonsillar capsule, and then snare the base off with a Tyding's or similar snare. I take special care that no hidden lobe at the upper or lower pole is overlooked, particularly one I frequently find well up behind the palatal folds, which is the usual location of a quinsy. This is the portion most commonly overlooked by the inexperienced operator. As a rule, no difficulty is encountered except in old quinsy cases with extensive scar tissue and adhesions outside the tonsillar capsule. Such cases require careful dissection in a good light, and in these cases particularly, the suction apparatus is of great advantage in affording a clear field of operation.

In such cases, the "machine" methods are unsatisfactory, though I grant that many tonsils can be removed quite well with some types of guillotines. The dissection method has one outstanding advantage over machine work. It can be adapted to any kind of a tonsil, and tonsils vary within wide limits, not only in size, shape, structure, location, accessibility, but in freedom from adhesions. A trephine is essential for some special kinds of work, but a scalpel is an all-round handy tool, like a jackknife, which can be adapted to a large variety of uses, and in the dissection method of tonsillectomy it will answer every requirement.

I use ether by preference, as stated. Where ether seems contra-indicated, operation under local novocaine anaesthesia as a rule works nicely. I have had no trouble from it in my own cases, but have seen some badly infected throats where the tonsils were removed under local. I have a strong conviction that I do better work under general anaesthesia, with the patient entirely relaxed, particularly in children and nervous subjects. My chief objection to local anaesthesia is, however, on other grounds—the greater liability to hemorrhage and the more frequent occurrence of infection. As to the former,

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hemorrhage after tonsillectomy is of three kinds, primary hemorrhages occurring during operation, secondary, due to sloughing, etc., this being a late hemorrhage, and what I call intermediate hemorrhage, coming on a few hours after operation. Coakley terms this "recurrent" hemorrhage but, for various reasons, I prefer the term intermediate.

Primary hemorrhage occurs invariably to a greater or less degree in all cases operated upon under general anaesthesia. Owing to the fairly common practice of using a small percentage of adrenalin with the novocaine in the local anaesthetic solution, the operation under local is a bloodless operation as compared with that under ether. I have little fear, however, of this primary hemorrhage since the patient is fully anaesthetized and everything including assistants, excellent lighting facilities, suction apparatus, mops, plenty of clamps, a ligature tyer, suture material, is at hand to control such bleeding effectively by the customary methods. I prefer to cope with my hemorrhages when I have every advantage and am fully prepared and expecting them.

I have an occasional case where there is a slight but persistent oozing following the operation, showing a hemophilic tendency. The usual methods failing to prove entirely satisfactory (pressure, coagulin in various forms, ice to the throat and all the customary routine in such cases), I finally tried hypodermic injection of morphine and hyoscine to equalize the circulation, having found it of value in a similar type of post-partum hemorrhage. It has proved effective in every instance in which I have had occasion to try it. I have not had, nor am I likely to have, enough cases of this type, to ascertain if this treatment will give uniform results, so I merely pass the suggestion on. If the line of cleavage between the glistening white capsule and the underlying structures is closely followed, the operation is greatly facilitated and the primary hemorrhage reduced to a minimum. R. H. Fowler stresses the advantage of his serrated tonsil knife in separating the strands of muscular tissue which are attached to the

groove between the upper and lower lobes. His argument is essentially reasonable but I cannot speak from any personal experience as to its merits.

Intermediate hemorrhage I have seldom seen in my own practice, but I have known of many cases and in every instance, so far as I could ascertain, it followed an operation under local and was, I have reason to believe, due to the secondary reaction when the effect of the adrenalin had passed off. Our knowledge of the action and reaction, the swing of the pendulum, in most drugs or remedial agents, would bear this out. It is on account of these intermediate hemorrhages that many operators insist on the patient remaining in the hospital until the day following operation. I have never seen a case of secondary hemorrhage proper in my own practice, but I have seen quite a number that were operated upon by other surgeons, having been called in to check the bleeding.

A secondary hemorrhage occurring in sloughing tissues, in the dead of night, at a private house, miles from one's office or from a capable assistant, with poor illumination and without a suction apparatus, with a panic-stricken household and a nervous patient, is a wholly different matter from a primary hemorrhage when everything is clear sailing, and has a decided tendency to render one's sudorific glands unpleasantly active. These cases are definitely due to infection and, logically, this brings up the matter of the relative safety of general versus local anaesthesia in these operations upon Waldeyer's ring.

Under either general or local anaesthesia, we have left a large cavity in the tonsillar fossa, on either side, which must heal under granulation. We will grant that in either case the operation is done with strict attention to asepsis and with equal skill. So far honors are even. We must balance the discomforts of etherization with the discomforts of throat instrumentation in a fully conscious patient. In either case, there should be no pain. So far it is a matter largely of individual preference.

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In the vast majority of tonsillectomies, save only those cases of simple hypertrophy, the tonsils are infected. Although the needle and solutions are absolutely sterile and the mucous membrane at the seat of the punctures is sterilized by iodine or other means, it must be remembered that such sterilization is of necessity superficial. The average tonsil operation requires that from six to eight punctures be made with the hypodermic needle in order to produce complete anaesthesia. These punctures *must necessarily be made through infected throat tissues* since it is impossible to sterilize the deeper parts. If the throat is *not* infected, one must admit that tonsillectomy is rarely justifiable, save when they are hypertrophied. The pain is greater after local than after general anaesthesia.

You have here, in addition to the two broad, open, self-draining wounds left after enucleation, from six to eight needle punctures which are impossible to drain and any one of these is a potential source of infection. A perfectly sterile needle may be passed through an infected focus, hidden and even unsuspected, and carry infection to neighboring tissues. I think we must admit that with local anaesthesia, the risks of infection are necessarily much greater and experience seems to bear this out.

In forty-five years of tonsil work, largely in the country where hospital facilities were not available, in tonsil clinics where a large number would be operated on in an improvised operating room located in some schoolhouse perhaps, or in my office where the patients could not be kept any length of time for subsequent observation, I have never had a fatality, never a pulmonary abscess, never a septic infection of the throat. I have had two cases of diphtheria following operation, and one case of pneumonia in an Indian child some five days after tonsillectomy. This does not necessarily mean that the pneumonia was due to the operation. In consideration of the frequency of pneumonia in children and the immense number of cases operated upon, it might easily

have occurred in greater proportion had these operations never been performed.

My comparative freedom from complications like pneumonia and pulmonary abscess I attribute, correctly or incorrectly, to the position in which I put my patients for operation, all fluid material in the throat tending to gravitate away from the laryngeal orifice. In the two cases where the operation was followed by diphtheria, there was no known diphtheria in the locality and neither I, nor any of my assistants, had been in contact with a diphtheritic case for a long time. Considering the very large number of cases operated on, it is reasonable to conclude that diphtheria developed in the wounds from germs already present in the throat or from extraneous causes.

I have had many primary hemorrhages in enucleation by dissection. The Sluder method avoids this, and in suitable cases is entirely satisfactory. My primary hemorrhages were never severe and I have had no secondary hemorrhages in the cases which I operated on personally. I have had no other accidents. I hear a lot about recurrences after removal of the tonsils. I have had three cases where I found it necessary to operate a second time. In each instance it was due to my failure to make a complete enucleation. I have yet to hear that any case I operated on has ever had further operative procedure on the part of any other doctor. I have seen a large number of incomplete removals, however, many of which I subsequently operated on. I no more believe that they can recur under complete removal than that a thumb or a pair of ovaries would recur after complete removal.

In quinsy cases, there should be no question as to the advisability of enucleation although such cases are often quite difficult. One attack of quinsy is more dangerous and causes more suffering than a tonsillectomy. Once the tonsils are completely removed, it is impossible to have a further attack. In chorea major it is usually wise to remove the tonsils, if the patient is in fit condition otherwise. The same is true of a

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large number of rheumatic cases and in a large variety of troubles if they are traced to tonsillar infections. I have seen a number of cases where chronic headaches ceased as soon as the tonsils were enucleated.

I have frequently removed tonsils from pregnant women, particularly in those who showed a tendency to nephritis, this with no trouble as a result of the operation but, I am quite sure, with distinct benefit. One of the most reliable indications of chronic tonsillar infection is the peculiar dusky redness along the anterior pillars. Where this evidence of chronic inflammation is found, unless there is some definite contra-indication, I am convinced that the tonsils should be removed. They may be of small size and apparently in a healthy condition but, after enucleation, the anterior pillars resume their normal pale pink color and the patient almost invariably improves.

In some obscure derangements of the nervous system of functional character, we occasionally get an astonishing improvement following tonsillectomy, showing that the focal cause has been removed. In tuberculous glands of the neck, the tonsils should be carefully inspected and if this is done, we will avoid not only recurrences of the glandular trouble, a possibly needless neck operation and unsightly scars but we lessen the danger of general tuberculous infection. I have frequently removed large tuberculous glands in the neck together with the tonsils at the same operation, the external and internal cavities being separated by only the thinnest of partitions. I have repeatedly seen enlarged tuberculous glands quietly disappear after tonsillectomy, without further treatment. The lymphatic glands of the tonsillar group are usually more or less evident in these tonsil infections and almost invariably melt away after tonsillectomy. It is commonly asserted that all tonsil cases should be operated on in the hospital. Adequate evidence to substantiate this claim has not yet been furnished.

Forty years ago, it was with the greatest difficulty that I

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could persuade parents to allow their children to be operated on for enlarged or diseased tonsils. Some of our doctors insisted that such operations were wholly needless, that the children would outgrow them at the age of puberty. One of them loudly proclaimed that I loved to cut children's throats. The poet Kemble wrote:

"Perhaps it was right to dissemble your love,
But why did you kick me downstairs?"

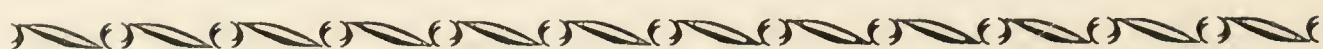
In later years this same practitioner sent me a number of his relatives and patients for tonsil operations and there has been, likewise, a wonderful change in public sentiment, a complete reversal of attitude since the days when cast-iron lions and deer on the front lawn were painted a life-like green; since the time when the popular magazines, like *Godey's Lady's Book*, advised every Christian mother to break up the pernicious habit of mouth-breathing in their offspring, using stern methods if required, when the poor little tots had no other way to breathe. Those were pre-eminently the days of "sound" sleepers. Today they come to us or call us up on the telephone to ask us what day they can bring two or three children for tonsil operations.

Many years ago I operated on a number of tonsil cases by means of the electro-cautery. The number of treatments required, the pain or discomfort of such treatments, and the scar tissue resulting therefrom, soon led me to abandon this method. Of late years electro-coagulation is being advocated largely on the claim that it is a bloodless method. I know little about this procedure having seen no cases operated on by this means and no opportunity to ascertain the end results.

I may be prejudiced in this matter but, having read much regarding it, before personally attempting the destruction of tonsils by this or similar methods, owing to the intimate relation between the tonsils and the carotid artery and other

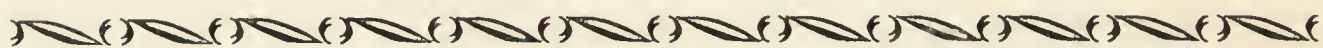
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important structures in the tonsillar fossa, I would want a course of intensive instruction at the hands of a skilled specialist in this line and, perhaps, some practical experience with an expert chef or cook.



LXXXV

EYESTRAIN



I CAN heartily endorse the stand taken by many of our eye-specialists that the majority of headaches are due to eyestrain, with the further comment that a majority of these eye-headaches are due to a latent or concealed hyperopia. I may also say that I have seen cases of chronic backache, inveterate stomach troubles, abdominal pains simulating chronic appendicitis (and frequently so diagnosed) and various other reflex troubles that were fully demonstrated to be due to eyestrain. That this was not the result of pure coincidence or due to imagination, was proven in various ways.

One woman left my office in high dudgeon because I did not give her medicine for a chronic indigestion of long standing but told her to wear the glasses I gave her and to return in two weeks to report regarding her stomach. Her husband insisted on her doing as she was told and she returned in two weeks in a totally different mood, having had no stomach trouble or headaches in the interval. Some cases of severe abdominal pain would remain free of any pain for years until their glasses were lost or broken: then the pains would promptly recur, to be immediately relieved on resumption of the requisite correction.

The various causes of headache are too numerous to be here considered. The statement holds that there are more headaches from eyestrain than from all other causes. Many patients are unable to understand how they can have eyestrain when they have excellent eyesight. Most of these patients have not only what is called normal vision but many have exceptionally good eyesight, yet they still suffer from eyestrain, still have serious refractive errors. Normal vision and

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normal refraction are not synonymous terms. It is also to be remembered that people who have extremely defective vision rarely have eyestrain; this on the principle that the man with a crippled leg seldom falls dead at the end of a 300-yard dash. He does not try to run races and the person who is half blind from a gross refractive error has long since learned that it is useless to attempt impossibilities, wherefore, as a rule, he does not suffer. It is the one who can see perfectly but by prodigious effort who suffers the most or, on the other hand, the milder cases who are compelled to use their eyes constantly for near work, in which case the effort and strain is not so severe but, being continuous, is quite as likely to cause trouble.

The normal eye until the age of about forty-five has a considerable amount of reserve focusing power, and it is no great effort to change from distant vision, during which this focusing power is not brought into play, to the reading distance which requires approximately a change in the refractive media of three dioptries to make it focus at 13 inches, the average reading distance, or one third of a metre. For precisely this reason, a person who has three dioptries of hyperopia, for instance, and this is a fairly well-marked hyperopia, may see perfectly at a distance but only by using the same amount of muscular energy, of focusing power, that the person with normal eyes uses for reading purposes. When he comes, however, to read, he must use six dioptries of focusing power. Even here he may be able to do it quite well temporarily, if not continuously, by calling upon his reserve.

His eyes are constantly under strain, and under a severe strain, under any conditions where he must use his eyes for near work. Yet he may "see" perfectly despite this handicap. These are the eyes that I call tiptoe eyes because I am in the habit of explaining to my hyperopic cases by a simple illustration what I mean. I go to a medicine cabinet and reach for a bottle on the top shelf, showing them that I can reach the bottle readily enough but that I am compelled to stand

on my tiptoes to do it and, that while this is the most convenient way of getting the bottle off the top shelf, if I were compelled to do work constantly at that height I would certainly need a platform of the proper elevation on which to stand. Then I point out the parallel, the lenses furnishing the platform for their "tiptoe" eyes.

It is for the very reason that hyperopics have apparently very good vision, that hyperopia is so commonly unrecognized by many who are, in other respects, very good lens-fitters. For the correction of hyperopia, the usual chart method of eye-testing is unreliable. The use of the retinoscope and the fogging test will, on the other hand, make the diagnosis perfectly clear in the vast majority of cases, even when the hyperopia is latent. It may occasionally be necessary to use atropine to paralyze temporarily the ciliary muscle and put it at rest. The focusing power of the eye is sometimes as difficult to measure as the length of a squirming angleworm, it being necessary to put the latter to sleep in order to have any two measurements agree. The dark room tends to relax the eye muscles and the retinoscope will not only show the nature of the defect but, in a large measure, its degree, at least to such extent as to enable us to fit the hyperopia, since these cases are seldom fitted up to the full limit.

If the retinoscope is used as a matter of routine, much time will be saved and there will be very few gross errors in fitting; without it, we find innumerable errors, some of them almost inexcusable. For confirmatory purposes and to ascertain just how much of the true correction the patient will accept, the fogging test is used. This is similar in most respects to the ordinary chart test with Snellen or other test type, save that we begin with strong convex lenses that will merely permit recognition of the largest type on the card. These lenses are gradually reduced in strength one-fourth of a dioptré at a time. In this way, relaxation of the ciliary muscle is automatically induced, since the patient sees well

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only when accommodation is relaxed. The strongest lens that will give good vision is the measure of what the patient needs as a rule, subject as in all such matters to the judgment and experience of the examining physician.

It is a common experience to find patients wearing minus lenses, ranging from — .50 to — 2.00 when they are really hyperopic and should be wearing plus lenses. Such misfits are plainly the result of improper methods of testing and will naturally aggravate the eyestrain instead of relieving it. I recall one young lady who applied for treatment. She had suffered from almost constant headaches for a number of years. When I started to test her eyes, she became rebellious immediately. She had four pairs of glasses, fitted by four specialists in various cities and could wear none of them with any comfort. Examination with the retinoscope, in a dark room, showed at once that she had an unrecognized hyperopia of four dioptries or more. It was a distinct case of ciliary spasm and a proper correction gave her immediate relief.

Hyperopia is occasionally the cause of anorexia of a chronic nature. I have seen children who never had any appetite (and in consequence thereof, were constantly thin in flesh,) become hearty eaters and grow plump or fat directly after correction of refractive errors by proper lenses. The change would be so immediate and so marked that it was unmistakable. If the present trend toward errors of refraction continues, it may become necessary to substitute phonographs, radios, movies and talking pictures for some of our textbooks, thereby lessening the strain of close work on the eyes of the pupils at the risk of wearing out their ears. Some such change is likely to prove beneficial, particularly in cases of progressive myopia. Headaches due to eyestrain are apt to disappear with the establishment of presbyopia, owing to impaired action of accommodation, but this, unless accompanied with correction of the refractive error, results in reduced visual acuity. I have found that headaches in young patients, with a hyperopia of one dioptry or less, are frequently relieved by tonsil-

lectomy, showing that the tonsillar infection was the chief factor in the production of the headache, the hyperopia still being evident.

Astigmatism seems to me the next refractive error, in frequency, as a cause of eyestrain headaches. The correction of astigmatism is a rather complicated matter and would require too much space to cover properly. This chapter is not intended to tell how to correct such troubles but to point out some of the more common causes of failure. There are many excellent textbooks on the correction of such defects and the reader is referred to these for detailed information. The reason that astigmatism is less apt to cause headaches, as compared with hyperopia, appears to be that in astigmatism, muscular effort overcomes the defect but imperfectly while perfect vision may be attained in hyperopia of moderate degree, but at the expense of eyestrain.

I find that prisms for esophoria and exophoria are frequently prescribed, when a proper correction of hyperopia or myopia causes the imbalance to disappear. Again, a somewhat similar condition of affairs is not uncommon, in that we meet with many cases wearing cylinder lenses for astigmatism, when the astigmatism is a false astigmatism due to an overlooked and consequently uncorrected hyperopia. With a hyperopia of more than one or two dioptries and a moderate astigmatism, it is a good rule, providing the patient has never worn glasses (and even so, occasionally) to correct the hyperopia and disregard the astigmatism. At the next examination it may be apparent that the astigmatism has disappeared, obviously having been due to over-strain of the eye muscles and a consequent distortion of the refractive media. At any rate, correction of the hyperopia will, in such cases, usually relieve the symptoms, giving satisfaction, and if the astigmatism still persists, it should also be corrected at the next sitting. I believe that some eye specialists will take exception to this statement and argue otherwise, but I am unafraid to let it go on record.

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So far as my observations go, myopia takes third place in headaches due to eyestrain. This would be logical for the reason that, although vision may be exceedingly defective in such cases, straining the eyes does not improve it in the least but, on the contrary, makes it worse. To formulate it briefly, no improvement, no effort; no effort, no eyestrain; no eyestrain, no headache.

The evils of uncorrected refractive errors are sometimes not fully appreciated and occasionally fail of recognition. A few years ago I was asked to examine a young boy in one of our hospitals. He was wayward, unmanageable and noticeably retarded in mental development, his case being considered rather hopeless. Noting the peculiar frown on his face and the way he screwed up his eyes when he looked attentively at anything in which he could be momentarily interested, I suggested a thorough eye examination, at least a careful retinoscopic test. He was found to have a decided error of refraction, was fitted with proper lenses, and within a year he became a practically normal child. This case is merely cited as an illustration.

In the routine examination of school children, the retinoscope is invaluable. The room is darkened and the children stand in a queue for the examination. With the retinoscope they can be passed on rapidly and with an accuracy and freedom from error that is a revelation to those accustomed only to older methods. Then the test-type may be used and those not showing 20/20 vision should be carefully re-examined and, if need be, at the doctor's office. I have habitually used this method since 1913 in the examination of school children. Given a room dark enough, homatropine is seldom necessary.

Eye-headaches may be orbital, supra-orbital, temporal, frontal or occipital. If located in or near the eye, they are apt to be unilateral and the reason for this is none too clear. I have never yet found a headache at the vertex that seemed to be due to eyestrain. Occipital headaches, due to eyestrain,

are fairly common. Some authorities claim that this is the result of muscular imbalance but I have not found this in the cases which came under my observation. If we follow the course of the optic nerves to the base of the brain, where they merge and cross to again converge at the posterior portion of the brain where visual impressions are received, we can possibly understand why occipital headaches may result. In my experience, dizziness is not a common sequence of eye-strain though many good authorities seem to find differently. I merely state this as a result of my personal experience.

True migraine is, quite commonly, independent of eye-strain. It may be allied to epilepsy and other nerve-storms. The present view is that it is an allergic manifestation due to edema of the nerve. It is apt to be a familial disease, coming from mother to son or from father to daughter. It is often brought on by the use of sweet milk, in which case, milk and lime-water, malted milk or buttermilk may prove efficient substitutes. This does not mean that the eyes should not receive proper attention, since a fair proportion of migraines are relieved by proper correction of visual defects. Many times an attack of migraine may be aborted by giving an emetic. This is an old-fashioned remedy but is none the less effective in old-fashioned migraine. To be of service it should be given at the beginning of the attack. Such patients seldom seriously object to the treatment, since they have learned by experience that vomiting is apt to occur before relief is secured.

Many years ago, before bifocal lenses attained their present popularity, I was criticized by various oculists for insisting that many of my patients with presbyopia added to refractive error, wear double lenses. They advanced numerous reasons for their position or for their opposition. Bifocals often are virtually a necessity and are now in universal use. Bifocals require careful fitting and accurate adjustment. They are an unmitigated nuisance for a time, until one grows accustomed to their use. On the other hand, two pairs of lenses

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in separate frames are a nuisance forever — if you live that long. As for getting accustomed to them, provided they are worn constantly, they give little trouble after the first few days or weeks. One does not expect to run a sewing machine, ride a bicycle or drive a car with any great degree of success on the first trial. The earlier they are worn, after reaching the presbyopic stage, the less divergence there will be in the relative strength of the upper and lower lenses and the more readily will the patient become accustomed to their use. Some nervous and sensitive patients find them quite troublesome at first, even when they are properly fitted. It is to be remembered that anything worth while is usually achieved only after earnest and persistent effort.

Heredity is an important factor in refractive errors. Some families show a marked tendency to myopia. In progressive myopia, I have reason to believe that undernourishment has a strong influence in its development. I know a number of families where either the mother or the father has hyperopia of a high degree and all the children, likewise. What is even more to the point is that the necessary correction is practically identical in all and they can wear each other's glasses with comfort and satisfaction.

One woman suffered from headaches from childhood. She had had her ears pierced seven times to relieve her headaches, naturally without much benefit. I fitted her with strong plus lenses and her headaches disappeared. She had a large brood of children and I fitted all of them with lenses much like her own, ranging from 3.00 to 4.00 dioptres plus. Someone had evidently tried to influence her, for she came one day with her youngest child and wanted me to prescribe something for the child's headaches. I examined the little one's eyes and told the mother that all she needed was a pair of glasses. The mother said, "Don't tell me that she needs glasses, too! Isn't there anything you can do for her headaches but fit glasses? I don't want her to wear glasses. I'm sick and tired hearing about glasses!" I grinned and told her I could pierce

the little girl's ears. The mother thought the matter over for a minute and then meekly surrendered.

Ciliary spasm commonly results from hyperopia. In other words, the hyperopic patient is altogether too accommodating and, as in other lines of endeavor, almost invariably gets into trouble.

The term "amblyopia" applies to defective vision not due to any *obvious* cause, *i.e.*, we speak of amblyopia due to tobacco, to wood alcohol or to simple disuse as in many cases of crossed eyes. This definition will be rejected by austere thinkers but will serve present purposes.

Uncle Eph remarked that "Si Perkins is an old-fashioned Democrat in politics, but in temperance and religion he's sort of neutral."

Aside from wood alcohol, we find other causes of toxic amblyopia. In rural districts, as I had occasion to point out as far back as 1904, hard cider may be an exciting cause. Many of our farmers keep a barrel or two in the cellar and a few dipperfuls of the stuff, if well ripened, will undoubtedly affect the overhead and disturb the correct balance. It will make the mouth taste like a bat's nest, will produce just as many plaid elephants and rainbow-hued toads as the standard equipment of Scotch and ginger ale through which the over-stuffed business man finds surcease from sorrow.

I merely mention this in passing, since these patients will commonly deny the use of intoxicants, and the real cause may be overlooked. If this is borne in mind, an occasional obscure case of impaired vision may be cleared up by removing the cause. I recall a friend of mine who was offered a glass of wine. Mournfully he said, "I beg of you not to tempt me. For twelve long years not an atom of that cursed stuff, not a drop of wine, brandy, gin, rum or beer have I allowed to pass my lips," adding in a lower tone, "I never drink anything but straight rye whiskey." He got what he wanted without marring his record.

I think we have all seen cases of serious eye trouble which

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were due to focal infection. I have had several cases of blindness in one eye in which the sight was completely restored simply by removing an offending tooth. We are beginning to appreciate the part that intra-nasal infections, such as we find in the ethmoid cells at times, may play in the etiology of optic neuritis and troubles involving the retina. The treatment of these conditions is becoming more satisfactory as specialists along these lines gradually solve the problems involved. We are already greatly in debt to some of these earnest workers.

Tobacco amblyopia is naturally much better known. It occurs not only among the wealthy from the excessive smoking of fat, black Havanas but in our French-Canadians with their tabac blanc, tabac Canadien, tabac Cat'olic which, being grown in his own garden is necessarily pure and health'y. It has, however, a strength which is truly remarkable. It has been said that the favorite perfume of a French-Canadian is a judicious blend of whiskey blanc, fried onions and tabac Cat'olic. This is not strictly true.

Toxic amblyopia due to various solvents used in the industries, to bisulphide of carbon, iodoform, the excessive use of tea or coffee and a host of other agents, needs no discussion here. Hypersensitives are always in trouble of some sort.

Those who have thoroughly mastered the use of the retinoscope in measuring the refraction of young children will, I think, agree with me that internal strabismus is due to hyperopia, external squint to myopia and that paralytic squint is comparatively rare. This in the vast majority of cases. Owing to inherent difficulties, refractive errors in children often are unrecognized, hence such cases are classed, not infrequently, as paralytic or due to fusion failure of central origin. When operating on cases of vicious squint, I have often found a rectus muscle so attenuated as to be almost unrecognizable although later, when the strabismus was relieved by operation and appropriate lenses, the muscle regained its full power. These are not cases of true paralytic squint. The weak muscle

had simply given up a hopeless struggle. The apparent atrophy was due to lack of exercise.

Correction of refractive errors in the very young will, in most cases, be all that is needed to straighten the eyes. To secure the best results, this correction should be made as soon as strabismus develops. I have had little difficulty in getting children to wear a pair of spectacles from the second year onward, when the parents would co-operate. In the very young, it is often necessary to fasten the temples to a tape which is tied at the back of the head. These eyes need to be corrected as fully as possible. By full correction I mean that obtained by the use of the retinoscope and atropine or homatropine. Most of these cases will accept a correction which is near this limit. I have seen a number of people, from fifty to sixty-five years of age, where marked strabismus was corrected simply by the use of proper lenses, but this is exceptional. Usually the "weak" eye has become hopelessly amblyopic from disuse.

If *full* correction of a hyperopia does not remedy an internal or concomitant strabismus, this being the common form, and the eye still turns in, operation is indicated *at an early age*, rather than to wait, as so commonly advised. The reason is that, to avoid annoying double vision in which the child sees two objects where there is but one, he soon learns to suppress and ignore any vision in the inturned eye, with the result that this eye rapidly becomes amblyopic and perfect vision is seldom recovered, no matter how skilfully the eye may be straightened. More than this, the eye not only remains more or less amblyopic but the operation is seldom entirely successful, showing a variable divergence at times. Like one blind horse in a team, it may be trained to follow its mate, after a fashion, but never quite perfectly. Early operation is therefore to be urged, not only to save the weak eye for useful vision, but to insure perfect results, rather than an unsatisfactory outcome which discredits the operation.

The operation for strabismus is a nice operation. Properly

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performed, it is safe, easy, practically bloodless and entails little discomfort to the patient. It is a delicate operation but not at all difficult, even when advancement of a muscle be needed which, in cases seen early, is rarely required. In the successful handling of strabismus cases there are a few essentials. Since, in the vast majority of cases, there will be found distinct errors of refraction, correction by glasses must be insisted on. *The lenses must be worn constantly.* Operations upon the muscles cannot remove the refractive errors. We must remove the cause, not content ourselves with removing one of the effects, else we can anticipate a return of the strabismus so long as the cause remains unrelieved. If proper correction is made at an early stage before one eye has become amblyopic to any great degree, and the lenses are worn constantly *after* operation, the results should be eminently satisfactory in all uncomplicated cases.

I know of few things more soul-satisfying than a viciously cross-eyed child who, after a minor and safe operation, regains a normal appearance in one week. He becomes a walking advertisement for the operator and for surgery in general, the sandwich man fading into insignificance by comparison.

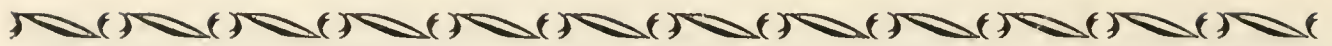
Dr. Jenkins had a bad case of temporary occlusion of one eye. Charlie Noreault had been on a batter and during a scrap had received a bad biff in one eye. It was completely closed and resembled an enormous blue plum with a definite crease running lengthwise and that delicate bluish bloom characteristic of certain blue plums and black eyes.

“Doc, can you see dose heye?”

“No, but I can see where it probably is.”

“What can you do (hic) for dose heye?”

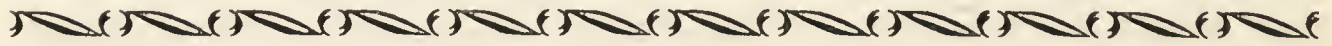
“Looks pretty bad, Charlie, but [hopefully] I might make the other one match it.”



LXXXVI

VARIOUS SUGGESTIONS

A gallimaufri or a potpourri



AN excellent rule to follow when one is called to some accident case or some emergency, and finds everyone keyed up and excited, is to get them all busy. Give them something to do and keep them from underfoot. People are anxious to help and, incidentally, to brag about it ever after. One of our local barbers dearly loved to tell how, when he lived at Tupper Lake, *he* and Dr. Austin amputated the leg of a lumberman. And there are so many odds and ends of things that we possibly may want, sterile water, hot water bottles, ice and ice-caps, mustard poultices, camphor, ammonia, rubbing alcohol, liniments, fresh sheets and pillow-cases, or old ones for possible outside dressings, sick feeders, extra wash-bowls, even telephone messages, anything to keep them out of mischief. Not all these are necessary for the use of the patient, but to restore order and inspire confidence. Satan finds mischief for idle hands and the sick-room is no exception in so far as these facilities are concerned.

Emergencies sometimes seriously upset our regular schedules. Uncle Eph apologized for delay in repairing my car after this manner. "Guess this here garage business is some like doctorin' folks. I had to haul in a wrecked car 'cause it was blockin' traffic on a narrer road and the feller's leg was busted. Makes me think of when Maria and me was keepin' house out on the farm. She was always a great complainer and mostly she had Doc Jenkins. He used to see her 'bout once a week. One time he got behind a day or so on his reg'lar visit and she was put out about it. Doc says, 'I was tied up on a confinement case and you had plenty medicine and weren't very bad

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off.' But Maria, she was too mad to listen. Doc kind of winks at me and says, 'Suppose some day someone knocks on the front door and you smell the bread burning in the oven, and the telephone rings, and the hired girl yells that the cows have broke into the corn and you see the baby topple over into a tub of hot water, *which do you do first?*' Maria says she'd get the baby out first, of course. Doc grins and says, 'That's what I was doing yesterday.' "

A large share of the emergencies which the general practitioner encounters occurs in the practice of obstetrics. It is no very unusual thing for the physician to arrive at some isolated farmhouse and find his patient well advanced in labor. The husband, unable to leave before, hurries away for help as soon as the doctor arrives. Meanwhile, the doctor is middling busy. He must prepare his own solutions, scrub up, be not only accoucheur but anaesthetist as well. He may find it far easier to wash and dress the baby and take care of the mother than to sit idly by for an hour or more until help arrives. After about three such experiences he is properly qualified to become a member in good standing of the Ladies' Aid Society and entitled to wear the emblem of that organization, which is a safety pin, couchant.

He will learn early in his career how to do an external, a bipolar or a podalic version. He must learn to use either his right or left hand, according to the position of the child, when a podalic is necessary. He must learn to do these things, or a high forceps operation, with little or no assistance. He must learn how to handle a face or a breech or an occiput posterior on his own without expert assistance if need be. He must learn that a primipara should not be hurried; here hyoscine and morphia is of great use. After an experience of some twenty-four years with it, I can say that I never saw it do any damage either to mother or child. He will occasionally have a type of post-partum hemorrhage, where there is a slow but persistent blood-loss not traceable to any bleeding point in a laceration, not amenable to ergot, pituitrin, douches

of hot sterile water and the usual remedies. Here he will find a hypodermic of morphia and hyoscine again of the greatest service.

In pulmonary atelectasis and asphyxia in the new-born, after all other methods of resuscitation have failed, I have very commonly brought these patients through by introducing a small rubber, or an English flexible catheter into the larynx and practicing inflation of the lungs in this way. This should be done about fifteen times per minute for a half hour if need be, using the utmost gentleness always, meanwhile keeping the baby warmly wrapped. This procedure is not at all difficult, providing the catheter be not too large, since it is a perfectly easy matter to reach and hook up the epiglottis in these young subjects, using the finger as a guide to prevent the catheter slipping into the oesophagus and to direct it into the larynx. I always carry a suitable catheter for this purpose in my obstetrical bag, since it takes little room and one never knows when he may need it. There is nothing new about this procedure but it is not used as frequently for resuscitating such cases as its success would seem to warrant. No force should be used in insufflating the lungs, otherwise harm may result.

He will learn that his sense of touch is in many instances far more adequate than any of his other senses; that the tendency to varicose veins during pregnancy may be kept under control by the use of a proper abdominal support and frequent elevation of the legs to temporarily relieve the distended state of the veins; that the woman who tells you her miscarriage was the result of having a tooth filled or extracted is merely using a convenient hook upon which to hang her cloak; that pregnancy should not be interrupted save for adequate and urgent reasons and adopt the method of Angus McFaa who, when taking a drink, was inclined "to simply lift up the jug and let nature tak' her coorse."

He will learn to avoid predicting the sex of an unborn baby. I tried it just once and my reputation never fully re-

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covered from that disaster. He will learn that a mouthful of decayed teeth is quite capable of explaining certain cases of puerperal infection which cannot be accounted for otherwise. He will learn to rule out an acute tonsilitis when some of his patients develop a high fever a day or two after labor.

He will learn, in other words, that the Lord helps those who help themselves, all of which will make a man of him. Not infrequently we are on some long trip, miles from our offices and any source of supplies and we are called in to some accident case. We may be wholly unprepared to cope with some of these emergencies. On one such trip I had to deal with a miscarriage at the fifth month. I could not detach the adherent membranes at the fundus for my fingers would not reach sufficiently high. It was impossible to introduce the hand. I hunted around the farm sheds, found a piece of bale wire and a pair of pliers, made a loop in the middle, twisted the two ends into a handle, bent the loop to the required curve, sterilized it by heating it to a red glow in the kitchen stove and cleared out the decidual membranes without any trouble, — having first cooled the curette.

Another time a team of horses ran away with a mowing machine attached, struck a stump and threw the driver in front of the cutter-bar. He was literally sliced into ribbons but none of the cuts were deep. I had some sterile catgut with me but used this all in tying vessels. Then I had several yards of cuts to sew up. I boiled a spool of sewing thread for some time and used most of the spool in sewing up the multitudinous parallel cuts. I got perfect primary union throughout.

We meet up with all sorts of accidents on these trips. We improvise splints for all sorts of broken bones. I have set any number of elbow fractures. I have had but one elbow in the lot where there was any deformity, loss of carrying angle or limitation of motion. This was a bad T fracture. I never use passive motion until final removal of the splints. These condylar fractures necessarily involve the joint and the quieter an injured joint is kept, the less inflammation and consequent

tendency to ankylosis. Passive motion may be all right but I never used it in these cases and see no reason why I should. A fracture well adjusted will stand a lot of letting alone. One cannot hurry the hatching of a set of eggs by putting three hens on the nest or by turning more heat on the incubating chamber.

In head injuries it is always well to remember that injuries to the frontal lobes are infinitely less serious than basal lesions. I have seen complete recoveries from very serious injuries to the frontal portion. I had a young German immigrant once who was struck in the head by the cow-catcher on a passenger train. I removed eight square inches of comminuted bone, about two cubic inches of disorganized brain tissue and he learned to talk passably good English in the six weeks I had him under treatment in the hospital. Many other surgeons have had similar experiences.

Nelaton's line and Bryant's triangle are very useful in locating the position of the great trochanter in hip injuries. I commonly use a tape-measure, passed snugly around the hips over the iliac spines and held by a pin or other means until one can view it from all sides and make sure that it is in proper position. The situation of the trochanters is then compared. This has no advantage over the other methods save that it is much simpler.

Textbooks on first aid usually, almost invariably, in fact, in dealing with the subject of bleeding wounds, recommend that, if the blood is bright red and is spurting or comes in a pulsing stream, a tourniquet of some sort be applied on the proximal side of the wound; if the blood is dark red and flows steadily, the pressure should be applied to the distal side. This is perfectly good advice, but in practice I find that blood is blood to most people, and it all looks bright red to them and always extremely gory, that they are unable to remember anyhow which is which. In their excitement, they get confused and put their compression in the wrong place, frequently doing more harm than good. If they were simply

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instructed to put a firm pad directly over the bleeding point and make compression over that, there would be but the one procedure to remember, and it would be far more practical. I offer this suggestion as a sort of first aid to the first aid writers.

During the World War, when everyone was trying to be of some service, I was asked to give a series of lectures on first aid. During one of these discourses which covered the treatment of wounds, I recalled an incident of the previous day, when the mayor of our town was inspecting some municipal construction work. A blast was set off and the mayor was struck on top of a bald and roseate head by a flying fragment of stone. Two other town officials were present and, pending my arrival, plugged the wound with a chew of tobacco to arrest the hemorrhage. I told my audience that, in case of similar hemorrhage, it was customary in some circles to procure a cobweb from the nearest poultry-house or pigsty, preferably one with a few dead flies in it, and pack this into the wound or, failing this, to take a cud of tobacco from a pyorrhoeic mouth or one with a few decayed teeth, and use this as a packing. I warned them that this had one drawback since, if the patient developed blood poisoning and died, which was likely to happen, the cud of tobacco would be a total loss. This passed entirely overhead. No one smiled or changed expression.

Hemorrhage after tooth extraction may occasionally assume importance. I have had a number of patients, living at a distance from my office, who were much exsanguinated upon my arrival. These hemorrhages are often quite persistent. One simple method of treatment is practically always available and effective. A small, hard, pill-shaped compress of absorbent cotton is rolled up and, if this be at hand, saturated with adrenalin solution, or with ordinary peroxide of hydrogen. Another firm compress is made, the size of a marble, the cavity left after extraction is cleared of clots, the small compress packed snugly in the cavity, the large compress

placed directly over the smaller one and the patient is instructed to shut his jaws tightly on this for an hour or more, at the end of which time the hemorrhage usually has ceased. This method has always proved successful though I have no doubt that in hemophiliac cases, where the tendency to bleed is extreme, it might be necessary to resort to other and more strenuous measures, including suture of the gums, but even so, this will control the hemorrhage until other treatment can be instituted.

For many infected wounds and for a large number of other local infections there is no better local application than the nitrate of silver stick. The "mild" lunar caustic stick is frequently preferable, being sufficiently strong for the ordinary run of cases and more manageable because less brittle. I have frequently met with the objection that it seals up the tissues of an infected wound, checking the discharge and locking in the poison. It certainly forms a film, combining with the albumin to form a silver albuminate, the film being thin but fairly tough and elastic, but it changes the entire character of the infected wound. Instead of a thin, sanious and highly infective discharge, puncture of the film at the end of twelve or twenty-four hours will give vent to what the old surgeons called thick, laudable pus, followed by rapid subsidence of the infective process and prompt cicatrization. I have seen this in so many thousand cases that this bogie-man of locking up the discharges merely makes me smile. Such a procedure is, however, contra-indicated in the presence of sloughing tissues or when there is *deep-seated* inflammation.

I recall one illustrative case among many. A boy received an infected scratch on one finger; this was followed after a brief interval by a chill and a temperature of 105. Examination showed an acute lymphangitis with a reddened streak running from the wounded finger up the arm to the lymphatic glands at the elbow and shoulder joints. In two hours the temperature and pulse became normal and on the following morning, some twelve hours later, there was no sign of

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any lymphangitis. The sole treatment given was opening the scratch and separating the sides to permit one application of the silver nitrate.

While we are on this subject of infected wounds, it may be well to mention briefly the common prejudice against rusty nails, brass pins and colored stockings. While this prejudice is due to a misapprehension of the facts, it is not by any means wholly unfounded. A brass pin is not dangerous because it is brass but because it has been in use a long time and is presumably infected. A rusty nail is one which has likely become infected with tetanus or other germs and, having a rough surface, is extremely likely to carry in such anaerobic organisms to the depths of a punctured wound and cause the gravest of infections. A colored stocking is not likely to be more injurious than a white one, but in the present state of our uncivilization, is infinitely more apt to be dirty. It is quite possible that the dyes used in colored stockings might on occasion prove irritant, even to the point of causing some inflammatory reaction, but the amount of such poison absorbed would be too insignificant to cause any really serious local or constitutional disturbance. The color of stockings is a matter of individual preference rather than of hygienic rule.

In dog-bites, the health authorities practically insist on the use of fuming nitrous acid in preference to any other agent for cauterization and if one fails to follow the established method of procedure, he is liable to get in wrong. These authorities maintain that such wounds heal as readily after the acid as after the use of other caustic agents. Regardless of its merits for the destruction of the virus of rabies, I have always found that this agent leaves an indolent suppurating ulcer which heals only after a protracted period and then with an hypertrophied scar as a rule. In this respect, it is surpassed only by hydorfluoric acid burns which heal only with extreme difficulty. I have gotten around this slow healing of the nitrous acid burns by a later cauterization with the stick of nitrate of silver which, after one application, will usually

so change the character of the ulcer as to cause rapid cicatrization. There can be no possible criticism of this method by the powers that be, provided the acid has been used in the first instance. We know that there is no incompatibility between the acid and the nitrate of silver.

In *burns*, especially those of the deeper sort, the method of treatment by spraying with tannic acid solution has many advantages. It is a comfortable treatment from the standpoint of the burnee, since the treatment is painless and no dressings are required; the tannin tans the skin, coagulating the albumin; there is no discharge worth mentioning, no disagreeable odor; absorption of decomposition products is avoided and in those burns where a large area is involved and which were formerly considered extremely dangerous, it is a life-saver.

In this connection, I may add that I have many times seen patients with severely burned or badly lacerated hands, who had their hands dressed with some ointment or lotion and then bandaged snugly to keep the dressings in place. Such things may be all right to try on one's enemies. A much more comfortable way of handling these cases is to dispense with the roller bandage entirely, using instead a large piece of sterile gauze which is wrapped around the entire hand and folded over, where there is a slack or surplus, in such a way as to form a loose mitten enveloping the hand, this being basted with a thread to hold it in shape. Such a mitten exerts no compression on the inflamed member, yet it will hold the dressings in place and can be removed without the slightest trouble. During sleep and particularly with children, roller bandages are apt to become loosened by unconscious and involuntary movements, and unless a bandage is applied very snugly and well, such displacement is bound to occur at times, affording an avenue for infection. If the bandages are placed snugly, they are of necessity more or less uncomfortable. I can heartily recommend this simple and effective dressing to those who have not thought this out for them-

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selves. I was severely burned about the face and hands myself a few years ago, from an explosion in my office, and I know the comfort which this loose mitten dressing affords.

Foreign bodies in the ear may be washed out with a good syringe, or removed with an ear spoon, probe, or suitably bent hairpin; the latter is practically extinct, however. A live insect may be drowned by filling the ear with oil. The end of a camel's-hair pencil brush may be dipped in acetone collodion and allowed to remain in contact with the object for a few minutes until firmly adherent, when both may be withdrawn. This is much better in every way than the glue which was formerly used in a similar manner, since it is much more apt to adhere and dries far more quickly.

The removal of ear wax is occasionally quite difficult. Here the instillation of peroxide of hydrogen will break up the mass and be of material assistance. People have often asked me how frequently a running ear should be washed out. The answer is, "Like your face or hands, as often as it gets soiled." It is wise to remember that many cases of "earache" are due to an infected or impacted lower wisdom tooth.

Foreign bodies embedded in the cornea are sometimes very difficult to see by artificial light when proper corneal reflection is not so easily obtained. In such case, a jeweler's loupe held in place by a light spring over the head, if one has not mastered the art of holding it like a monocle, is of advantage. Oblique illumination, using a flashlight and strong focussing lens to concentrate the light, aided if need be by a fluorescein stain, should enable one to locate the foreign body.

Foreign bodies in the nose can frequently be removed by closing the patient's mouth firmly with the palm of the hand, introducing a large piece of rubber tubing in the opposite nostril and blowing forcibly. For this purpose, a Politzer's bag is serviceable. This failing, the foreign body can usually be hooked out with a bent hairpin or similar improvised tool.

Epistaxis can often be relieved by plunging the hands and feet in very hot water. Frequently the bleeding comes from a

minute point on the septum and, with a good headlight or an electrically lighted nasal speculum, can be touched with the electro-cautery. Packing with gauze wet with adrenalin or peroxide is effective if the bleeding part is not too far back. If this be the case, a post nasal tampon, with a string through the nostril to hold it in position while the anterior of the nose is packed, is effective. I once used such a packing and told my patient to return in twenty-four hours for its removal. He got impatient with the tampon and journeyed a long distance to a hospital without my knowledge. They attempted to remove the packing by pulling on the string which protruded slightly from the nostril. He had a whale of a time and two weeks later I removed a piece of gauze from his nose which was the foulest-smelling thing I have so far encountered. In nasal hemorrhage an ordinary rubber condom, introduced well back and packed with absorbent cotton, is quite effective.

When foreign bodies, such as pins, safety pins, pieces of chicken bones, etc., are lodged in the oesophagus, the lower end is usually caught in the mucous membrane and the upper edge wedged down by attempts at swallowing. Here any attempt to force it down by a bolus of food or a probang is not only doomed to failure but may cause serious injury. Under these conditions I have frequently, and in fact almost invariably, been able to remove such objects by a very simple procedure. I give my patient about a pint of cold, sweet milk. This forms a heavy coagulum in the stomach in the course of twenty minutes or so. Then an emetic of apomorphia, hypodermically, will relax the oesophagus, produce sudden vomiting and the heavy curds, forced upward, release the impacted end, and the foreign body is carried up with the vomitus. If this fails, the hospital, the specialist, and the roentgen ray come into service, but they will seldom prove necessary if no forcible attempt to crowd it down has been previously made. Occasionally a patient will come into the office complaining that a tooth-brush bristle or a small fish-

bone has lodged in the throat. Some of these cases are purely imaginary. If such a body is really lodged in the throat, it will usually be found in a tonsil or possibly in some of the folds around the epiglottis. It may sometimes be rendered readily visible by staining with some of the harmless blue aniline dyes or with blueberries if these are available. Failing this, recourse may be had to the bristle probang. In the case of small fishbones, a mixture of essence of pepsine and hydrochloric acid, taken in small doses at frequent intervals is efficient, the acid dissolving the mineral constituents of the bone and the pepsine digesting the remainder.

In cases where children choke from some foreign body in the throat, it may perhaps become necessary to explore the pharynx with the finger. Since time is here of the utmost importance and a suitable mouth gag may not be improvised readily, the following plan may prove serviceable. With the patient seated on the floor and in the grasp of your knees, the mouth is opened and the cheek pushed in between the molar teeth with one hand while search is made with the fingers of the other. With the cheek so held between the patient's teeth, there need be no fear of his shutting down on your fingers. In these throat cases, a bristle probang or a coin-catcher may be of service, but if the foreign body is not too far down, the finger, or a careful search with a good headlight, is preferable.

One is occasionally called to cases of edema glottidis. Where this is due to nephritis, scarifications of the swollen tissues, followed by a good dose of calomel and a brisk purge will, as a rule, give quick relief. The most frequent cause, so far as my experience goes, is angioneurotic edema. The attacks come on very rapidly and I have more than once been called in to intubate these cases or do a tracheotomy. I have never found that this was necessary. A hypodermic of adrenalin, or, lacking this, a hypodermic of apomorphia to produce prompt vomiting, has invariably given quick relief. These cases all demand iodine or the lime salts in order to prevent

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recurrence, otherwise they will likely have repeated attacks. There is a close kinship between urticaria, agioneurotic edema, "dead" fingers and Raynaud's disease in some respects.

In paronychia, I have learned slowly but painfully that in many cases removal of the nail, or an incision, is needless, provided the infection has not involved too much of the matrix. It is quite commonly the result of getting infectious or irritating materials under the fold of the skin at the side of the nail, and is therefore very often found in workmen employed in certain trades that render them thus liable. Taxidermists engaged in upholstering pet Pomeranians not uncommonly have two types of paronychia, one which seems to be due to the irritant effect of the arsenical preparations used in preserving the skins. This form is always strictly localized and shows little tendency to involve the entire matrix. The other form appears to be due to germ infection, doubtless from the partially decomposed animal fluids. In this class of cases, the infection spreads rapidly, affording an excellent illustration of the difference between chemical and bacterial poisoning, either being capable of causing intense inflammatory reaction, but the action of the chemical is limited, because of its essential nature, while the bacterial infection is alive and, under favorable conditions, can extend indefinitely. It is always possible, of course, as in taxidermists' paronychia, to have both factors at work simultaneously but the bacterial infection is the one that is capable of causing systemic involvement.

Be this as it may, if the case is seen sufficiently early, while the inflammation is limited to the side of the nail, it can be readily relieved by sterilizing the eye of a coarse needle or blunt spud (a silver probe is too flexible) and burrowing under the edge of the nail laterally, a little posterior to the junction of the nail with the fold of the skin, pushing the fold aside to enable the edge of the nail to be elevated, whereupon a drop or so of pus will escape. All that is ordinarily

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necessary is to sterilize the focus with iodine or mercurochrome, apply a wet dressing and repeat this drainage in the same way twice a day until the inflammation subsides. Paronychia is a minor affection but the relief afforded by this comparatively painless method is great.

In *phlebitis*, which most frequently occurs along the course of the saphenous vein, absolute recumbency is indicated. In the course of a long and arduous medical career, it has been my misfortune to know of a number of cases of phlebitis that died of pulmonary embolism due to neglect of this precaution, a loosened clot being carried in the bloodstream through the right heart to the pulmonary vessels. In phlebitis and in cases of phlegmasia alba dolens particularly, recovery is much hastened by giving potassium iodide. I have seen many cases of the latter trouble that were very obstinate until this plan was adopted, whereupon there was a prompt change for the better. Echinacea is often of much service in phlebitis cases.

Not infrequently, in the case of automobile accidents, for illustration, we have cases of sudden faintness or syncope. The usual treatment is to lay the patient flat in order to bring the blood back to the brain but, since these accidents are prone to occur in wet weather, it not infrequently happens that the ground is muddy, the grass wet and the car overturned or on its side. In such a case, it is well to recall that equally good results may be achieved by seating the patient and leaning him forward with his head well down between his knees.

On a number of occasions it has so happened that I was compelled to do a tracheotomy when time, help and proper instruments were sorely lacking. A set of tracheal cannulas and an intubation set miles away at my office were useless. There was no choice but an immediate operation with perhaps a scalpel and an artery clamp or two. Ordinarily the trachea can be opened with two strokes of a keen knife. On the other hand, the operation may present difficulties. I recall

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one case of enormously swollen submaxillary cellulitis and another one of inoperable tumor of the neck where tracheotomy was none too easy. Again, a blacksmith was kicked by a horse, the toe calk fracturing the larynx. On my arrival he was deeply cyanosed and he had a neck of elephantine proportions due to emphysematous swelling.

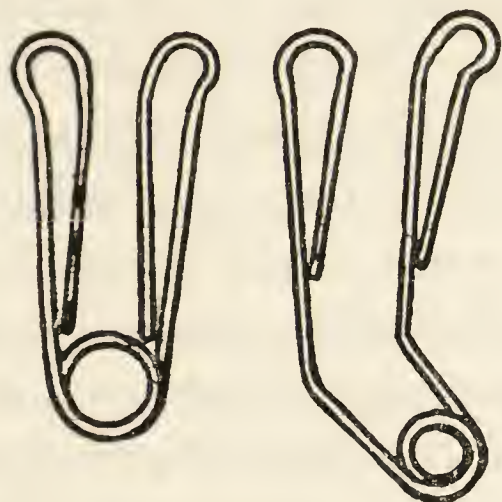
None of the standard-sized tubes are of use in some of these cases, provided they are at hand. A suture can be introduced through each lip of the trachea and tied to an elastic band at the back of the neck, but this practically necessitates the use of a full curved needle which is not always available. In cases like the last one cited, rapid subsidence of the swelling renders this method unsatisfactory.

The simple self-retaining retractor, which I devised many years ago for these emergency cases, reduces the number of instruments actually required down to one — a knife. It does away with all excuses for failure to operate. Hemorrhage is, as a rule, slight and easily controlled. The handle of the scalpel, or even a side pressure of the blade will serve to keep the tracheal wound open long enough to enable a retractor to be improvised.

A probe from a pocket case, an old-style hairpin will do; in one case wire unwound from the butt of a broom served the purpose. Double the wire in the form of a wishbone giving it a turn and a half at the center, around a pencil, fountain pen or thermometer case. If the wire is soft, like stove-pipe wire, an extra turn or two is needful to furnish the necessary spring. Bring the two ends parallel. Bend back these ends to form broad fenestrated blades or loops. Give these blades a moderate outward curve at the tips to make them self-retaining. Break off any surplus wire over the base of a knife blade. Sterilize it by flaming or in any convenient way. Close the blades and insert in the tracheal opening. A tape passed through the ring of the retractor and tied back of the neck gives a feeling of security but is not essential. You then have time to go back home and procure a tube to your liking or

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you can go to bed, with the consciousness of a duty well performed.



This simple device has certain advantages. It costs nothing. It is always available. It will not clog with mucous during your absence. It has never caused any irritation or discomfort in any of the cases in which I have used it. It can be adapted to the requirements of the individual case by making the blades large or small, long or short, curved or straight. In the case of a foreign body lodged in the larynx, it gives an open field for inspection and, unlike the tracheal cannula, offers no obstruction to its escape. In an emergency these advantages are manifest.

Moles should be removed if they are disfiguring, if they tend to grow in size, if they are melanotic in character or if they are troublesome in any way. Fifty years ago there was a strong prejudice against their removal on the ground that any interference was likely to lead to malignant degeneration. We were warned to leave them strictly alone. This did not seem reasonable to me; it looked like hitching the cart in front of the horse and I made it a rule, when I operated under general anaesthesia, to search for and excise any disfiguring moles before my patient regained consciousness. I knew I was taking a chance, that if anything went wrong I ran the risk of a malpractice suit, but I had no troubles of any kind and my patients were all grateful when they found out what I had done.

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After I left the hospital in New York, many people, mostly of the theatrical group, journeyed to our town in search of "the doctor who removed moles" and, since that time, I have removed many thousands of them, wholesale and retail. I took out 48 at one sitting from one patient's face. The transformation in his appearance was so remarkable that I did not recognize him at the end of a few weeks when we again met. I had two cases where keloidal hypertrophy of the scars occurred but, in both instances, these eventually disappeared. I have never seen malignancy develop in the scar nor have I had any other troubles with them. If properly removed, they do not recur. Large moles I remove by excision under local anaesthesia. Occasionally this requires a little plastic surgery to cover the defect smoothly. Small dermal sutures, properly placed and removed early, are advisable and the scars left are not visible except on close inspection. Small moles can be readily destroyed by the use of a fine electro-cautery point. Women are sometimes subject to the development of small but numerous moles on the face and neck, some being pigmented and flat, others small and pediculated. These can be snipped off and the bases destroyed by the electrolysis needle. Melanotic moles and those which show rapid growth, should be removed by Marsden's paste, the method being described under Skin Cancer. The results are all that can be desired.

LXXXVII

MEDICAL SUPERSTITIONS

“Glistered the dire snake and into fraud led Eve our
credulous mother.”

SOME years ago I had a patient with a severe and hopeless case of spinal trouble. For her own comfort and welfare it was necessary to restrict her activities to a large extent. One day she begged to get out of bed and attend the County Fair at Malone some sixteen miles distant. When permission was refused she grew very angry and said, “Doctor, if you don’t let me have my way about this, I swear I will come back from my grave and haunt you.”

I smiled serenely and said, “I wish you would, Jennie, I have always wanted to see a real ghost and, so far, I haven’t had any blamed luck.” The poor girl died over twenty years ago but my lack of luck still holds.

When I was five years old, my father (reading aloud from the *Montreal Transcript*) read a prediction by some soothsayer or geomancer to the effect that a planet was rapidly approaching the one we inhabit, would collide with it and destroy it utterly and completely. He made no comment. The day was near at hand and, in my case, the nights were filled with horror and terrifying dreams. I saw moons, planets and comets wildly cavorting through the heavens, bringing sudden death and general desolation. Early on the appointed day I had a grandstand seat in our front yard. I knew we were all doomed to destruction but I wanted to see the show. Evidently there was a hitch in the proceedings, some delay in the schedule, for I distinctly recall going into the house and (being unable to read the time) asking what time it was and if the clock was right. I did this so frequently that my

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mother's curiosity was aroused and she questioned me. When I broke completely down and told her all my fears, she comforted me and wisely counseled me not to believe all I heard.

Taking this maternal advice as seriously as I had taken the false prophecy, I began a series of tests and experiments. It was bad luck to spill salt, to break a mirror, to start anything on Friday, to walk under a ladder, to drop a dishcloth, to speak of good luck without knocking on wood, to hear a rooster crow in the evening, to sit thirteen at a table, and so on down the interminable list of people's pet superstitions or what have you. With infinite patience I trained our rooster to crow every time I baited him with corn, thus starting early on a career of bribery and corruption. I spilled salt deliberately and broke pieces of mirror-glass which I found in the attic. I knocked the dishcloth from my sister's hand; I ran circles around a leaning ladder. With malice aforethought as our legal friends say and as my parents doubtless believed, I tested out all these undisputed sayings left to us in entail by the light-weights of the Dark Ages. I had a certain measure of bad luck but it was not according to schedule.

My parents strove earnestly to correct my perverse ways by remonstrance and, this failing, by applying a slipper as far back as I can remember or as far back as you can imagine; on the back of my lap, to be more precise. At the time it seemed to me to be a low-down trick to play on an earnest and sincere seeker after truth, engaged in experimental research, though I may not have phrased it in exactly these words. But nothing really serious happened save that I gradually lost faith in the accumulated wisdom of the centuries. I no longer accepted as absolute truth things that were merely based on someone's say-so without any apparent reason back of them.

Recently I reviewed my publications during the past fifty years and was impressed with the conviction that this early trend had followed me (or led me) throughout life to a large extent; that it has led me to puncture many undesirable and

unsightly blebs on the sere and wrinkled skin of our medical beliefs. It has possibly given me a different attitude from that which has been considered strictly normal and conventional. In some respects I have lived mentally alone, have practised my profession largely alone, have strayed from the beaten path at times, as such are prone to do. Occasionally I have had the temerity to put what seemed to me reason and logic above mere precedent. Some of us have been born wrong end to. I have been dubbed a medical heretic — and worse — and for this I am sorry but unrepentant. Men who have the courage of self-respecting lice must stand by their convictions. Anyhow, after the locomotive and the first three Pullmans have run over you, the rest is dead easy, as a rule, and may be viewed philosophically or totally disregarded. I don't mind criticism if it is not too vicious or given such a nationwide broadcast as to blot out the original contention. My friend, Dr. Gardner, came in from rabbit hunting one evening. After two liberal helpings of creamed chicken he was offered a third.

"Thanks, I don't mind if I do," said he, "but I wish that you wouldn't say it so loud."

Somehow I am unable to believe that fevers turn on the ninth day, not the kind of fevers that we have up here in this North Country, or that a broken bone knits on the ninth day. I cannot believe that it is wise to *rub* a frozen ear with snow, that pneumonia is a disease, that a small naevus on the baby's back is the direct and indisputable result of the mother having picked a *pailful* of strawberries the previous June, or, always, that the patient would have certainly died if the doctor had not reached him just in the nick of time. I question if people directly inherit a liking for whiskey, else why do some of them shudder so when they take it? I could believe, I think, that a degenerated moral fiber, a weakened self-control, due to constant self-indulgence, might be transmitted. I have a feeling that, if one wanted to quit the whiskey habit, the tobacco habit or any other habit and

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wanted to quit it harder than he wanted to keep on drinking or smoking or whatever he was doing, that he would simply quit. These chaps that say they can't are simply kidding themselves. When an abstract desire collides with a concrete impulse, I've usually noticed that the undisciplined take a fall.

I cannot even subscribe to Eli Dufresne's theory without some qualification. He was accustomed to come to town every morning about six o'clock with a load of milk to ship on the early train. On three such mornings within a fortnight, I rose in my pajamas, sterilized a pair of forceps and a hypodermic and relieved him of an aching tooth, slipping promptly back in bed to get a further nap. On the last occasion he did not leave as promptly as I could have wished but paced about my office, rubbing his jaw with his hand and muttering, "I can't understand dis, me. I can't get it t'rough my head no-how."

"What is it you can't understand, Eli?" I asked.

"How, all on account of Adam and Eve, I got for lose all my teet' in 1918."

Eli was a little queer. He had the usual complement of brains but the mosaic was of an uncommon pattern. Human frailty has ever sought something whereon to hang its hat. It naively assumes that all time-honored sayings must be true.

Take this matter of maternal impressions. Somehow I am unconvinced that the boy baby weighed $12\frac{3}{4}$ pounds *because* the expectant mother incautiously glimpsed through an open window a neighbor's hog carrying a superabundance of lard. It doesn't look quite reasonable to me. One can see in nine months so many things even more impressive. Again, there are so many fat babies, so many obese hogs, so many expectant mothers! And why stop at $12\frac{3}{4}$ pounds when the hog weighed two hundred?

Women come to my office and tell me that, on account of some special occurrence, they just know that the baby will be "marked." Formerly I was accustomed to give these

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women my solemn assurance that, while I had seen many marks on a large number of babies, in no instance had the mother been able to predict with any degree of accuracy the *nature* of the mark. In no instance where a baby had been born with a mark and I called the mother's attention to it, had she been able to account for it promptly. After many sleepless nights she was usually able to give some plausible explanation, but it always seemed to me that an impression, sufficiently strong to work structural changes in the child, should not have faded to such an extent from her memory that it was only after prolonged effort that she could recall it. All my seeds of logic fell on stony ground or by the way-side and that was that. Now I take from the lower left-hand pigeonhole of my desk a small cartoon from the *Saturday Evening Post* which depicts a distracted and perturbed hen frantically trying to round up a brood of diminutive Ford cars which are blithely speeding in various directions from a nest containing only broken and empty shells. The hen shrieks, "I just knew something awful would happen after my being so nearly run over by that flivver three weeks ago." In this automobilious age I find this sketch more effective than argument.

Once I had a patient with syringomelia, a laundress. She had lost all sensation of heat or cold and, in handling hot irons, she had literally cooked all the flesh on the palms of her hands without realizing it so that her hands became hopelessly crippled. I reasoned from this and other things that pain, suffering and discomfort were the warning signals of Nature showing us that we were doing ourselves some injury, rather than evidence of error of mortal mind. We pound our thumb with a hammer and it hurts, *ergo*, be more careful. Could it be possible that an All-Wise Intelligence knew what He was doing when He arranged these sensory nerves after a definite and systematized plan? That may be Christian science as distinguished from Christian Science.

Ill-health, sickness, infections, morbid growths, injuries

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and the like may be simply errors of mortal mind and, like the thumb, the hammer and the pain, merely sinful delusions or hallucinations, but, to me, the delusion seems to be fundamental and basic in that it gives a false interpretation not only of the Scriptures but of undisputed facts. Possibly I am not endowed with the proper mental stature and I am like the small boy on his way to the dentist with a torturing tooth. A Scientist said to him, "Little boy, why are you crying?"

The boy said, "I've got a gosh-awful toothache."

"But your tooth doesn't really ache. You only think it aches."

"You're a dad-blamed liar!" said the lad.

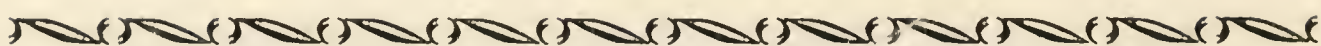
"There was a faith-curist named Neal
Who said, 'Although pain isn't real,
When I sit on a pin and it punctures my skin,
I dislike what I fancy I feel.'"

I am inclined to believe, with Emerson, that every sweet has its sour, every evil its good. I strongly favor the somewhat Calvinistic doctrine of Dr. A. Conan Doyle who says in his *Religio Medico*:

"God's own best will bide the test, and God's own worst
will fall;
But, best or worst, or last or first, He ordereth it all,
For All is good, if understood. (Ah, could we understand.)
And right and ill are tools of skill held in His either hand.
The harlot and the anchorite, the martyr and the rake
Deftly He fashions each aright its vital part to take.
Wisdom He makes to form the fruit where the high blossoms be,
And Lust to kill the weaker shoot, and Drink to trim the tree,
And Holiness that so the bole be solid at the core;
And Plague and Fever that the whole be changing evermore.

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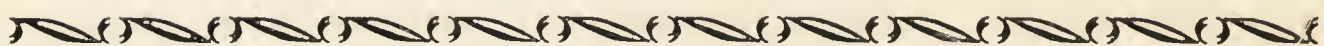
He strews the microbe in the lung, the bloodclot in the
brain;
With test and test He picks the best, then tests them once
again.
He tests the body and the mind, then rings them o'er and
o'er,
And if they crack He throws them back, then fashions
them once more.
He chokes the infant's throat with slime, He sets the fer-
ment free;
He builds the tiny tube of lime that blocks the artery.
He lets the youthful dreamer store great projects in his
brain,
Until He drops the fungus spore that smears them out
again.
He stores the milk that feeds the babe, He dulls the tor-
tured nerve,
He gives a hundred joys of sense where few or none might
serve;
And still He trains the branch of good where the high
blossoms be,
And wieldeth still the shears of ill to prune and prune His
tree."



LXXXVIII

REFLECTIONS

“What haunts me now that my years have fled
And the days of my life are few?
The thing that I did? By the God of my soul!
The thing that I failed to do.”



I AM now in my seventy-sixth year, in excellent health, still practising, not from financial necessity but because I love to; with a help-meet loving and lovable, the girl whom I chose as my head nurse in Bellevue; with children of whom I am proud; with enough grandchildren to make me feel something of a patriarch.

When I was a youngster I sang in Sunday-school, “I want to be an angel and with the angels stand,” (substituting rather indistinctly) “but to postpone it forty years or longer if I can.” In other words, I was willing to be an angel but not this coming Thursday, if you understand what I mean. In this respect, at least, and speaking purely from a numerical standpoint, I have been successful since I have lived beyond the allotted span. Temporarily I am AWOL to the disgust of many of my patients but I am preparing to return north and I know that many of them will be pleased for they have gotten used to me and have missed me.

I have worked hard but have enjoyed it. I owe no man a dollar. I am still able to enjoy a battle with a big shark off a Florida key, a vacation on Lac St. Francis, or a long day in the woods after grouse. I can look back with keen enjoyment to my first surgical patient, a pet canary with a broken leg. When necessity arises I can, as of yore, still operate with a steady hand and a stout heart on a formidable case. In some ways I have become armor-plated and case-hardened in order

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to survive the strains and stresses which have fallen to my lot, but I never have become immune to distress, suffering, wanton cruelty or needless bloodshed in any living creature, for which, although a surgeon, I am thankful.

I have had many a Blue Monday as who has not? Days when I had a dozen houses to visit at any one of which I might see crape and a floral wreath on the front door upon my arrival. Days when I had to operate on some little child who would look at me in piteous fright, not being old enough to comprehend why I was compelled to do painful or uncomfortable things to her innocent person. Days when I brought pitiable and undesired babies into an inhospitable world, a world resentful of their arrival, realizing however that O. O. McIntyre stated a naked truth when he said that there are no illegitimate children, only illegitimate parents.

I have done my best in so far as it was given me to see it at the time of the doing. I have been a more or less constant contributor to medical and other journals. The manuscript of the present book lies before me, ready to send to the publisher with the apologies of the perpetrator. Much of it may be blue-penciled but that does not disturb me. To paint the thing as one sees it is at least a high endeavor.

My chief regret is not for the thing that I did but for the thing that I failed to do. I am a simple country doctor but I have been of service to my community. I do not envy the men in my beloved profession who have gained fame and fortune in wider fields. They can be no happier than I who have lived a full life and have achieved my heart's desire. I have little sympathy to waste on the present-day advocates of the more abundant life, of perfect equality of working hours, wages, food, opportunity and living conditions in general. The world owes no man a living, simply the right to earn a living by his own efforts. These desirable things are to be had, as a rule, if we seek them earnestly. The world will be glad to take care of the exceptions. One of the few places where these living conditions are equal is the penitentiary

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and, almost to a man, the inmates are dissatisfied and rebellious.

Looking back over the years that have fled, reviewing the progress that has been made in the alleviation of human misery and suffering, anticipating the further advancement of this good work which is inevitable, my only real regret is that seventy-five years is so wofully inadequate and insufficient to carry out all the things that I would love to do.

Spending most of these years in a little village, I have had to practise largely by myself. For this reason my views may be narrow but I hope not unduly so. I have a feeling that I have overworked the first person singular in this book but, if I wrote the book at all, this was unavoidable and I can only beg the reader's tolerance and forbearance. If I have related too many incidents which might indicate too much self-esteem, I do not really believe it is due to egotism. In recalling interesting happenings, perhaps we are all led without volition to dismiss and forget unpleasant things, to recall and remember happy occurrences, which may be all to the good. It may well be a natural defense mechanism of which we are wholly unconscious. "Laugh and the world laughs with you. . . ."

And now, having gotten these things out of my system albeit in a most unsystematic way, I will journey home and, some lovely afternoon, I will loose the painter of my small boat, tune up the little motor to its proper pitch and let it sing me down the placid Salmon, across the peaceful international boundary line, waving a friendly hand to the Canadian border officials at Dundee, down to Crown Point, Nigger Point, past Bateau Creek, Butterball Bend, Pike and Sucker Creeks, Portage Island and through the Mile Stretch. I will skirt Gunboat Island formed in midstream where a fleet of flat-boats was sunk in the war of 1812 to avoid capture by the British forces; down past Oak Island and The Gut to the Salmon's mouth and to the clear blue waters of the St. Lawrence.

FIFTY YEARS A COUNTRY DOCTOR

I will see if the muscallunge, the doré or the small-mouth bass are in biting or fighting mood, watch the blue-wing teal and the black mallards winging by, listen to the "scaipe" of the jacksnipe, the soft, questioning whistle of the plover, the chatter of the long-billed marsh wren, the querulous notes of the gallinule and the pied grebe, the occasional weird and mocking laughter of the great northern loon and, as the sun lowers, turn westward to our little lodge on Hopkins Point.

Here in its quiet beauty is the site of an ancient Mohawk camping ground where, underneath the sod, Indian arrow-heads are to be found. In the tribal language it is called *Tai io ton nia te ko wa*, (phonetically, Gee ju doon nya dea go wah), The Big Point.

Here I shall dress my fish, watch the sun, God's sun, setting in the west over the reed-beds, the great blue herons crossing the sky to their rookeries in the tamaracks beyond the wild cranberry marshes, the irregular files of crows going west to their roosting place in the pines below the Indian village of St. Regis and, lighting my briar pipe, I shall enjoy the soft colors of the afterglow with a long sigh of contentment, remembering the promise that in the sweet fields of Eden there is rest for the weary.

THE END

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